RETURN DATE: NOVEMBER 7, 2023

CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INC.	:	SUPERIOR COURT
	:	JUDICIAL DISTRICT OF NEW BRITAIN
v.	:	
	:	AT NEW BRITAIN
CONNECTICUT DEPARTMENT OF PUBLIC HEALTH	:	OCTOBER 6, 2023

PETITION FOR ADMINISTRATIVE APPEAL

TO THE SUPERIOR COURT FOR THE JUDICIAL DISTRICT OF NEW BRITAIN ON THE SIXTH DAY OF OCTOBER, 2023, COMES CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INC., APPEALING PURSUANT TO SECTION 4-183 OF THE CONNECTICUT GENERAL STATUTES FROM THE FINAL DECLARATORY RULINGS [CORRECTED] OF THE CONNECTICUT DEPARTMENT OF PUBLIC HEALTH, DATED AUGUST 24, 2023, AND COMPLAINS AND SAYS:

PARTIES AND JURISDICTION

1. Plaintiff Connecticut Association of Health Care Facilities, Inc. ("CAHCF"), is a Connecticut trade association and advocacy organization which includes 151 skilled nursing facility members. Its offices are located at 213 Court Street, Middletown, Connecticut 06457. CAHCF is an association permitted under Conn. Agencies Regs. § 19a-9-9 to file petitions for declaratory rulings.

2. Defendant Department of Public Health ("DPH") is an agency of the State of Connecticut that seeks to protect and improve the health and safety of the people of Connecticut.

3. CAHCF brings this petition and complaint pursuant to Section 4-183(a) of the General Statutes.

4. CAHCF, on behalf of its members, is aggrieved by the Final Declaratory Rulings [Corrected] of DPH, dated August 24, 2023 (the "Declaratory Rulings") (attached as ***Exhibit A***), because the Declaratory Rulings: (1i) violate Section 19a-563h of the

General Statutes; (ii) are clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; and (iii) are arbitrary or capricious, or are characterized by an abuse of discretion or a clearly unwarranted exercise of discretion. *See* Conn. Gen. Stat. § 4-183(j).

FACTUAL BACKGROUND

5. Section 19a-563h of the General Statutes establishes minimum staffing levels for Connecticut's nursing homes.

6. Pursuant to amendments effective as of May 23, 2022, Section 19a-563h requires DPH to "establish minimum staffing level requirements for nursing homes of ***three hours of direct care per resident per day***." Conn. Gen. Stat. § 19a-563h(a)(1) (emphasis added).

7. Section 19a-563h commands the Commissioner of DPH to adopt regulations to set forth nursing home staffing level requirements and to implement the provisions of the statute. The Commissioner of Public Health may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulations, provided notice of intent to adopt regulations is published on the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted and further provides the Commissioner with permissive authority to implement interim policies and procedures pending adoption of final regulations. Conn. Gen. Stat. § 19a-563h(b).

8. Before Section 19a-563h was enacted, the Connecticut General Assembly had refrained from adopting minimum staffing level requirements for nursing homes even though such requirements had been proposed many times over the last decade, instead

maintaining the more aggressive and flexible approach under state regulations that mirror strict federal staffing requirements. These former staffing requirements focused on ensuring sufficient staffing to meet the individual needs of nursing home residents, while state regulations also provide for minimum staffing levels.

9. Specifically, DPH regulations require that each nursing home "employ sufficient nurses and nurse's aides to provide appropriate care" to residents and that the "number, qualifications and experience of such personnel shall be sufficient" to assure each resident receives care and treatment as prescribed in the patient care plan; be kept clean, comfortable, and well-groomed; and be protected from accident, infections, or other unusual occurrence. Conn. Agencies Regs. § 19-13-d8t(m).

10. The prior regulations further required that the nursing home administrator and director of nurses meet at least once every 30 days to determine the number, experience, and qualifications of staff necessary to comply with these staffing requirements.

11. Finally, the prior regulations required nursing homes to provide patients with a minimum staffing of 1.9 hours per patient per day from a combination of "total nursing and nurse's aide personnel."[1] Conn. Agencies Regs. § 19-13-D8t(m) (requiring staffing of 1.4 hours per patient from 7 a.m. to 9 p.m., and .5 hours per patient from 9 p.m. to 7 a.m.).

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[1] Conn. Agencies Regs. § 19-13-D8t(a)(11) defines "licensed nursing personnel" as "registered nurses or licensed practical nurses licensed in Connecticut." "CNA" is separately defined in Section 19-13-D8t(a)(3) as "a nurse's aide issued a certificate – from January 1, 1982 through January 31, 1990 – of satisfactory completion of a training program which has been approved by the department."

12. Although a subset of the 1.9 hours of staffing per patient per day was required to be from "[l]icensed nursing personnel," *i.e.*, RNs and LPNs, *see id.* (requiring staffing of licensed nursing personnel for .47 hours per patient from 7 a.m. to 9 p.m., and .17 hours per patient from 9 p.m. to 7 a.m.), the Public Health Code permitted nursing homes full discretion and flexibility to staff the balance of the minimum hours between licensed nursing and nurse aide personnel based on the needs of individual patients.

13. The prior DPH regulations are consistent with federal regulations, which similarly place focus on ensuring sufficient staffing to meet the particular needs of the facility's residents, requiring that each nursing home "have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, *as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at 483.70(e)."* 42 C.F.R. 483.35 (emphasis added).

14. When the General Assembly, in the 2021 session, sought to codify minimum staffing levels in nursing homes, it initially considered a bill that would not only increase the minimum hours to 4.1 hours of direct care per resident per day, but also would impose statutory minimum staffing levels based on licensure status, *i.e.*, minimum hours for RNs, LPNs, and CNAs.

15. The full legislative body rejected that proposal in the final version of S.B. No. 1030.

16. Instead, the legislature increased the minimum hours (from 1.9 to 3.0) while specifically eliminating mandated staffing ratios without specifying *any* minimum hours

based on *any* licensure status. This left intact the flexibility required for nursing homes to staff at different levels based on patient needs.

Legislative History of New Statute

17. Section 19a-563h began as Senate Bill 1030, introduced during the January 2021 legislative session, in which the following language regarding minimum staffing level requirements was initially proposed in the Senate:

> Sec. 13 (NEW) (Effective October 1, 2021) … (b) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for nursing homes of at least four and one-tenth hours of direct care per resident, including *three and three-quarter hours of care by a registered nurse, fifty-four hundredth hours of care by a licensed practical nurse and two and eighty-one hundredth hours of care by a certified nurse's assistant*, …

(emphasis added). *See* ***Exhibit B*** (S.B. 1030, Original Draft).

18. The initial draft of the bill not only increased the number of direct care hours per patient from the DPH-regulated 1.9 hours per day to 4.1 hours a day, but it also included particular ratios based on licensure status.

19. At hearings on S.B. 1030 in March 2021, numerous interested parties, including the DPH Acting Commissioner and Commissioner of the Department of Social Services, Dr. Deidre S. Gifford, submitted testimony regarding the proposed minimum staffing level requirements.

20. While agreeing with the desirability of creating statutory minimums at levels higher than the existing DPH regulations of 1.9 hours per patient per day, many of those presenting testimony criticized mandated staffing ratios based on licensure status and supported continuing the same degree of flexibility in staffing based on patient needs, as federal and state regulations had allowed for decades.

21. Notably, DPH Acting Commissioner Dr. Gifford gave testimony *supporting* the continued flexibility in determining appropriate staffing within minimum staffing level requirements rather than imposing staffing ratios on nursing homes:

> The Department recommends all facilities have adequate staffing with the appropriate competencies and skill sets to provide nursing and related services, *based on a facility assessment*, to assure resident safety and attain or maintain the highest practicable level of physical, mental, and psychosocial well-being of each resident. The facility assessment uses individual resident assessments and plans of care to ascertain the number, type of diagnoses, and acuity of the facility's resident population. In the nursing home setting, regulations require that the administrator and director of nursing meet monthly *to determine adequate staffing levels using a tool based on the acuity of their current resident census*.

Exhibit C (emphasis added) (Gifford Testimony).

22. Dr. Gifford, as Acting Commissioner of DPH and Commissioner of the Department of Social Services, expressly recognized and supported the need to allow each facility to determine independently how to fill the minimum staffing levels to meet patient needs, consistent with the flexibility that had been fostered and permitted under DPH's existing regulation. *See* Conn. Agencies Regs. § 19-13-D8t(m).

23. CAHCF's President and CEO, Matthew V. Barrett, also testified, raising two significant concerns with the proposed ratios in S.B. 1030: (i) reduced flexibility in the proposed legislation in allowing nursing homes to direct the percentages of staffing resources, between RNs, LPNs and CNAs, based on specific care needs of individual nursing homes, and (ii) increased labor costs to achieve the proposed minimum staffing that would result from the mandated percentages, especially for hiring additional CNAs to meet the specific mandated ratios. ***Exhibit D*** (Barrett Testimony).

24. Mag Morelli, President of LeadingAge Connecticut, also questioned the wisdom of the proposed specific ratios per licensure category. While supporting an

increase in overall hours per patient per day, Morelli did not support the mandated ratios of RNs, LPNs and CNAs which would completely remove the critical flexibility nursing homes needed (and DPH regulations previously allowed) to determine how best to staff those hours based on changing patient needs. ***Exhibit E*** (Morelli Testimony).

25. In addition to eliminating flexibility in staffing decisions, S.B. 1030, as originally drafted, caused concerns over the significant fiscal impact of the staffing ratios. At a Senate hearing on March 17, 2021, Dr. Gifford, as Acting Commissioner of DPH and Commissioner of the Department of Social Services, was specifically asked whether DPH and the Department of Social Services was in favor of the proposed staffing level ratios in the existing version of S.B. 1030, to which she responded:

> I think the Department would like to continue to have the conversation of minimum staffing ratios. We certainly understand the impetus behind it and ensuring that there is always adequate staff to meet the needs of the residents based on their acuity. While I think we would also want to talk about the implications of the minimum staffing ratios *or financial support of the facility*, so I think we probably are aligned on the intent and want to just engage you a little bit more on the specifics and how it would be implemented and *supported*.

Exhibit F, at 20 (Connecticut Committee Transcript Excerpt, PH 3/17/2021) (emphasis added).

26. In sum, Dr. Gifford declined to offer support for the existing version of S.B. 1030 until, among other things, the financial support for the proposed staffing ratios could be properly vetted.

27. The Office of Fiscal Analysis then prepared and submitted an analysis of the financial impact of the original proposed staffing ratios in the File Copy of S.B. 1030. "*Staffing ratio requirements will result in a significant cost to DSS* to the extent nursing home staffing costs are reflected in future Medicaid payments … The cost for

nursing homes to staff at the proposed levels will depend on the actual number and level of staff required and their associated wages but is anticipated to *be at least $200 million*." ***Exhibit G*** (April 13, 2021 Fiscal Note, Office of Fiscal Analysis).

28. When S.B. 1030 was taken up on the floor of the State Senate prior to the end of the 2021 session, the Public Health Committee Chair offered an amended version of S.B. 1030, referred to as Senate Amendment Schedule "A" to S.B. 1030, which eliminated the staffing ratios by category of personnel, and reduced the minimum staffing level requirement from 4.1 hours to 3.0 hours of direct patient care per day. *See* ***Exhibit H*** (Amended S.B. 1030).

29. The Office of Fiscal Analysis Fiscal Note on the amended version of S.B. 1030 confirmed that the amended bill (based on an evaluation of 2019 cost report data) – without mandated staffing ratios – would have a nominal financial impact:

> The amendment requires the Department of Public Health (DPH) to establish a minimum staffing level of three hours of direct care per resident per day, by January 1, 2022. Based on 2019 cost report data, there are several homes providing less than three hours of direct care per resident per day. The total cost for these homes to meet the bill's provisions is approximately $600,000 to $1 million. ***If the state supported those costs through increased rates, it would result in a state Medicaid cost of $300,000 to $500,000***. The actual cost depends on the number and type of staff required.

Exhibit I (May 27, 2021 Fiscal Note, Office of Fiscal Analysis) (emphasis added).

30. In advocating for the passage of this modified version of S.B. 1030, the Chair of the Public Health Committee, Senator Mary Daugherty Abrams summarized the new language in the provision on minimum staffing, noting that "changes have been made to address the fiscal note and feedback from various stakeholders." Senator Daugherty Abrams continued that "[s]taffing would be increased. Currently it's 1.9 hours per resident per day. This would increase that to 3.0. It would also increase the ratio of social workers

from one to 120, to one to 60, and increase recreational staff as determined by the public health department." Senator Abrams emphasized the mandated staffing ratio for social workers, but specifically addressed only the overall increase in nursing and nurse's aide hours from 1.9 to 3.0 per day, making clear her committee had rejected including ratios for nursing personnel. *See* ***Exhibit J*** (Connecticut Senate Transcript Excerpt, 5/27/2021).

31. Senator Heather Somers further stated clearly that the new version of the bill "starts the beginning of the process, I believe, a process to improve the long-term care that we can provide to our citizens in the State of Connecticut. It looks at infection prevention, infection control, it looks at staffing levels *that are reasonable and are affordable*. It looks at emergency plan. It deals with visitation of loved ones. It deals with patients' rights." *Id.* (emphasis added).

32. Based on the data, testimony and important policy considerations, the mandated staffing ratios were eliminated. Section 19a-563h was enacted, providing:

> (a) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for nursing homes of three hours of direct care per resident per day …

The statute eliminated any specific minimum hours or ratios based on licensure status, consistent with the testimony of the DPH Acting Commissioner and others. By eliminating specific staffing ratios, the statute preserved nursing homes' flexibility to determine – based on patient needs – the staffing arrangements most appropriate to meet the increased minimum staffing levels.

33. The General Assembly allocated $500,000 in state funding to DSS for two fiscal years to support the minimum staffing levels imposed by Section 19a-563. This level of funding was entirely consistent with the Office of Fiscal Analysis Fiscal Note that the cost of increasing the minimum staffing level to three hours of direct care per resident

per day – without mandated staffing ratios – would be nominal, an estimated $300,000 to $500,000. *See* ***Exhibit I*** (May 27, 2021 Fiscal Note).

34. As such, the General Assembly's allocation of $500,000 to support the increased costs of Section 19a-563h further supports the legislature's intent to increase the total hours of direct care ***without*** imposing the mandated staffing ratios that were estimated to have a far greater significant financial impact. *See* ***Exhibit G*** (April 13, 2021 Fiscal Note, estimating the financial impact of the original S.B. 1030 – which included mandated staffing ratios – to be $200 million).

35. DSS interpreted the statute the same way. In anticipation of the effective date of Public Act 21-185, now codified as Section 19a-563h, DSS included guidance for nursing homes on its website that specified the General Assembly had allocated up to $500,000 in state funding to DSS for the next two fiscal years to support the minimum nursing home staffing requirement, reflecting the figures in the May 27, 2021 Fiscal Note. This guidance reflected DSS' belief that the final statute did not require any mandatory staffing ratios – consistent with its plain language – since including mandatory staffing ratios would have substantially increased the associated costs.

36. In a joint Blast Fax to nursing home administrators from the Commissioners of DPH and DSS, dated February 9, 2022, the Departments confirmed that "DSS has also received an allocation of $500,000 in state funding, for Medicaid, to support nursing homes in meeting the staffing requirement of three-hours of direct care per resident per day." ***Exhibit O*** (Blast Fax 2022-14, February 9, 2022), at 2.

37. It is clear that the statute was intended to ***not*** require mandatory staffing ratios. An interpretation that mandatory staffing ratios are permitted under Section 19a-563h would impose significant financial burdens that are not supported by the statute, that

are not funded by the General Assembly, and that – as a practical matter – increase the financial instability of Connecticut's nursing homes and undermine their ability to deliver quality care.

DPH Policies and Procedures to Implement Section 19a-563h

38. Section 19a-563h(b) also authorizes the Commissioner of DPH to implement interim policies and procedures "necessary to administer the provisions of this section … while in the process of adopting such policies and procedures as regulations, provided notice of intent to adopt regulations is published on the eRegulations System not later than twenty days after the date of implementation."

39. The February 9 joint Blast Fax specifically referenced the new DPH policies and procedures that were in the process of being amended in compliance with Conn. Gen. Stat. § 19a-563h(b), but which had not yet been finalized. DPH and DSS encouraged nursing homes to nonetheless take steps to begin complying with the new statutory staffing levels: "since these current regulations are minimum staffing levels, nursing homes are encouraged to begin to comply with staffing requirements 1 and 2 outlined above[2] and in public Act 21-185 within their facilities so they can be prepared for the Department's adoption of the new regulations." *Id*. Significantly, DPH and DSS – in the Blast Fax – leave the determination of how to allocate staff to meet the new three-hour minimum staffing requirement entirely within the discretion of each nursing home. *Id.*

[2] The staffing requirements referenced in the Blast Fax correspond with the new statute: "1. Have a minimum of three hours of direct care per resident per day; 2. Have one full-time social worker per sixty residents; and 3. Lower the requirements for recreational staff as deemed appropriate by the Commissioner of Public Health." *Id.*

40. Inexplicably, several months after the Blast Fax was issued, DPH issued an Operational Policy entitled “Policies and Procedures regarding Nursing Home Staffing Levels to implement the requirements of Section 19a-563h,” which amends the existing regulations in Conn. Agencies Regs. § 19-13-D8t(m) (the “Policies and Procedures”).

41. In November 2022, DPH posted a Notice of Intent on its website with DPH’s initial draft of the new policy. Despite the plain language of Section 19a-563h and the opposition during the legislative process for mandatory staffing ratios – including by DPH’s Acting Commissioner – DPH nevertheless drafted language in the Policies and Procedures to specifically allocate the three hours of minimum staffing among different levels of staff, taking the discretion away from nursing homes to make staffing decisions based on the individual care needs of residents. Specifically, DPH reversed the longstanding policy of allowing nursing homes to use a combined total nursing and nurse's aide personnel in determining direct care staffing levels.

42. On information and belief, DPH did little or no research on best practices for nursing home staffing prior to issuing the draft policy. No research or studies were offered in support of the draft policy. DPH also failed to seek any public input in the process of drafting the language with specific staffing allocations. Indeed, DPH leadership indicated that the staffing ratio determinations were based on “anecdotal” information provided by the Connecticut long-term care ombudsman and other outside groups. Recommendations made by CAHCF and LeadingAge Connecticut were dismissed.

43. Despite serious concerns expressed by industry stakeholders, including CAHCF, on February 22, 2023, DPH conducted an industry-wide presentation, again confirming that, despite serious concerns expressed by nursing homes, DPH planned to move forward with the policy specifically allocating the three-hour minimum staffing

requirement between licensed nursing staff and nurse's aides. *See* ***Exhibit P***, DPH PowerPoint Presentation, February 22, 2023, at Slides 15-27. DPH also announced that the new policy, in Conn. Agencies Regs. § 19-13-D8t(m)n, would go into effect a week later, on March 1, 2023.

44. DPH did not just increase the minimum staffing to 3.0 hours of direct care per resident per day, as mandated in the statute; DPH incorporated those specific minimum hours between licensed nursing staff and nurse's aide staffing per resident per day, requiring: (i) for licensed nursing personnel (RNs and LPNs), 0.57 hours per patient during day shifts (7 a.m. to 9 p.m.) and 0.27 hours per patient during night shifts (9 p.m. to 7 a.m.); and (ii) for CNAs, 1.6 hours per patient during day shifts (7 a.m. to 9 p.m.) and 0.56 hours per patient during night shifts (9 p.m. to 7 a.m.). Most significantly, without any statutory direction to do so, DPH eliminated the longstanding state policy of combining "total nursing and nurse's aide personnel" in determining the direct care minimum staffing level.

45. In addition, the Policies and Procedures add an ambiguous definition of "direct care." These interpretations are clearly contrary to the legislative intent evidenced in the final fiscal analysis dated May 27, 2021, which is uses 2019 cost report data to conclude a nominal fiscal impact resulting from the passage of Section 19a-563h.

46. Given that the General Assembly rejected any allocation of minimum hours among different nursing staff categories, it is clear that the state legislature intended to leave specific staffing choices to the individual nursing homes, which are in the best positions to assess the specific needs of individual patients and determine specific staffing to meet those patients' needs.

47. The General Assembly's decision to leave specific staffing choices to individual nursing homes is evident given the significant fiscal impact that mandatory staffing ratios would pose for nursing homes and the State.

48. More particularly, the initial Fiscal Note on the original draft of S.B. 1030 made clear that imposing the minimum of 4.1 hours of direct care per resident per day, plus imposing mandated staffing ratios, would cost DSS as much as an additional $200 million per year.

49. The second Fiscal Note, addressing the amended version of S.B. 1030 that both reduced the minimum hours from 4.1 to 3.0 of direct care per resident per day and eliminated all mandatory staffing ratios, anticipated increased costs of between $300,000 and $500,000 per year. DSS then had an additional $500,000 allocated for Medicaid costs for subsequent fiscal years, reflecting the clear intent to allocate to DSS additional funding to cover only the increase in minimum staffing levels to 3.0 hours *without* accounting for additional costs of mandatory staffing ratios.

50. The DPH Policies and Procedures do not take these financial impacts into account, and would impose an unfunded mandate that the legislature expressly chose not to impose, thus violating the statute.

51. Not only do the Policies and Procedures violate the plain language and legislative intent of Section 19a-563h, they represent a significant, overreaching departure from DPH's *existing* regulations regarding staffing ratios for nursing homes. *See* Conn. Agencies Regs. § 19-13-D8t(m).

52. These regulations – which were the sole source of minimum staffing levels for nursing homes before the enactment of Section 19a-563h – permitted nursing homes to staff 1.5 hours of the total minimum 1.9 hours of direct care with any combination of

“total nursing and nurse's aide personnel” based on patient needs; only 0.4 hours of the minimum time was expressly allocated for licensed nursing professionals.

53. DPH cannot regulate beyond this without specific legislative authority, approval, and funding.

54. Yet, the Policies and Procedures as written have significant fiscal impact, in stark contrast with the nominal impact included in the fiscal analysis.

55. The legislature clearly intended for the minimum staffing ratio to be established as a combined total of licensed nursing staff and nurse’s aide personnel, consistent with the existing Public Health Code methods.

56. Instead, DPH has created two separate minimum staffing levels, one for licensed nursing staff and one for nurse’s aide personnel, which is a major change that will significantly increase the fiscal impact and require staffing modifications for over 100 nursing homes.

57. In addition, in at least two presentations on the new Policies and Procedures, DPH has incorrectly claimed that the new Policies and Procedures only increase the total minimum staffing levels by 0.46 hours per day. This is clearly incorrect, as the minimum staffing levels are increased by 1.1 hours per day overall (from 1.9 to 3.0) and the Policies and Procedures establish for the minimum staffing levels for nurse’s aide personnel, at a level of 2.16 hours per patient per day, a dramatic increase for nurse’s aides from 1.26 hours per patient day, without any statutory direction to do so.

58. The Policies and Procedures undermine and contradict the plain language of Section 19a-563h and its clear legislative intent, and implement mandates that the legislature specifically sought to avoid when it modified the proposed legislation to delete

staffing ratios. In addition, substantively the Policies and Procedures are not supported by proper procedure and/or substantial evidence.

59. While the General Assembly authorized DPH to implement interim policies and procedures, DPH was not given authority to ignore the plain language of the statute or its legislative history. Accordingly, the Policies and Procedures that mandate particular minimum staffing ratios to meet the minimum staffing levels for nursing homes violate Section 19a-563h, and its purpose and intent. In addition, to the extent that DPH intends to craft regulations that incorporate any staffing ratios, for the same reasons set forth above, those regulations also would violate Section 19a-563h.

60. The General Assembly intended to preserve flexibility for nursing homes to determine how best to meet the new minimum staffing level requirements based on individual patient needs, not arbitrary, fixed staffing ratios. Section 19a-563h must be read to allow nursing homes to make those staffing decisions, so long as the minimum mandate of 3.0 hours of direct patient care is achieved and staffing is sufficient to meet patient needs.

CAHCF's Petition for Declaratory Rulings

61. On February 28, 2023, CAHCF filed a Petition with DPH seeking declaratory rulings that confirm that the new statute does not reverse the policy of flexibility in determining the appropriate combination of nursing and nurse's aide staffing that has existed in Connecticut for over 30 years, and rather continues that policy of flexibility – while meeting the increased minimum total hours – as the General Assembly plainly intended.

62. More particularly, CAHCF sought declaratory rulings that (i) under Conn. Gen. Stat. § 19a-563h(a), nursing homes should satisfy the minimum staffing level

requirement of three (3.0) hours of direct care per resident per day with three (3.0) hours of total nursing and nurse's aide personnel time; and (ii) regulations, policies and procedures promulgated by DPH with respect to minimum staffing level requirements that set specific minimum staffing levels for each category of nursing services (RNs, LPNs, and/or CNAs) for those three (3.0) hours of direct care per resident per day violate Conn. Gen. Stat. § 19a-563h(a).

Declaratory Rulings

63. DPH's Commissioner issued Declaratory Rulings [Corrected] on August 24, 2023, rejecting CAHCF's arguments that DPH had improperly promulgated policies and procedures in setting specific minimums for licensed nursing staff and nurse's aides.

64. More particularly, the Commissioner interpreted Conn. Gen. Stat. § 19a-563h, purportedly under Conn. Gen. Stat. § 1-2z, as specifically obligating DPH to allocate minimum staffing levels between licensed nursing staff and nurse's aides to meet the three-hour minimum staffing requirement.

65. DPH had the authority to draft and implement policies and procedures for implementing the 3-hour statutory minimum staffing level requirements in Conn. Gen. Stat. § 19a-563h.

66. The Commissioner also concluded that DPH had properly and appropriately promulgated policies and procedures under Conn. Gen. Stat. § 19a-563h by setting specific minimum staffing hours for licensed nursing staff and nurse's aides for those three hours of direct care.

Request for Reconsideration

67. On September 8, 2023, CAHCF filed a Request for Reconsideration with DPH on the grounds that (i) the DPH decision contains errors of law regarding the proper

statutory construction and interpretation of the minimum staffing mandate in the subject statute, Conn. Gen. Stat. § 19a-563h, and (ii) new evidence exists which materially affects the merits of the case which evidence was not available until after submission of the Petition.

68. With respect to the first ground, CAHCF argued that it had demonstrated, in its Petition, that the legislative history of Conn. Gen. Stat. § 19a-563h reflected the General Assembly's intent to increase the minimum number of hours of direct care per patient to three hours per day, but to do so in a cost effective manner and to allow staffing assignments to be determined by nursing homes based on the specific (and often changing) needs of their residents. More particularly, the legislative history of Conn. Gen. Stat. § 19a-563h demonstrates precisely that the General Assembly moved from including specific minimum staffing levels by category to simply requiring the increase in direct care time per patient to three hours, removing the specific staffing levels from proposed legislation and demonstrating the intent to not include them. The new DPH policies and procedures ignore the legislative history and clear mandate from the General Assembly to consider the fiscal impact of setting specific staffing levels.

69. As to the second ground, since CAHCF filed the Petition on February 28, 2023, new evidence became available that was not available at the time of filing which materially impacts the Commissioner's analysis.

70. First, during an Appropriations Committee hearing on March 3, 2023, the Commissioner was questioned by State Senate Appropriations Chair Catherine Osten specifically about this issue and the cost implications of forcing nursing homes to comply with the new DPH policies and procedures. *See* ***Exhibit K*** (March 3, 2023 General Assembly Appropriations Committee Tr. Excerpt), submitted herewith.

71. Senator Osten clearly states that the General Assembly "did a combination" of nursing and nurse's aides to fill out the three-hour period, and that DPH then decided to break it down by specific categories. *Id.*, at 35.

72. Most significantly, DPH's policies and procedures did not appear to take the cost impact into account at all, leaving Senator Osten wondering how nursing homes would be compensated for the higher costs and whether DPH and DSS had collaborated on the policies and procedures. *Id.*, at 35-36.

73. Demonstrating that the DPH policy is significantly misaligned with its available resources, the Department of Social Services has implemented an application process in an effort to provide substantial additional funding to offset the increase in costs for staffing CNAs at 2.16 hours per day per patient when, to provide the highest quality care to their patients, nursing homes need more RN or LPN hours, the costs of which were not included in budgets.

74. New data on the DSS website reflects that, since the DPH policies and procedures on staffing went into effect, 72 nursing homes have had to request additional funding to offset staffing costs. *See* ***Exhibit L*** submitted herewith, also available at https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-Nursing-Home-Reimbursement/Medicaid-Nursing-Home-Reimbursement/Pension-and-Wage-Increase.

75. However, DSS has provided only $1 million from the $22.7 million requested from those nursing homes. This is merely 4.4% of the requested amount.

76. Put another way, 95.6% of the requested amount was not provided to the nursing homes, leaving nursing homes with the added costs of nearly $22 million (as predicted in the first Fiscal Note, ***Exhibit G***). This only reflects the 72 that actually

applied. Based on CMS reports, the data shows that over 100 nursing homes will need additional resources to comply.

77. Further, in support of CAHCF's continued assertion that Connecticut nursing homes meet the minimum staffing requirement of 3.0 hours of direct care per resident per day, as required by Section 19a-536h, by staffing the requisite hours through a combination of total licensed nursing and nurse's aide personnel, and by allowing nursing homes to direct the percentage of staffing resources between RNs, LPNs and CNAs based on the care needs of the facility's residents, CAHCF requested that the Commissioner of DPH consider the recently released Center for Medicaid and Medicare Services ("CMS") commissioned *Nursing Home Staffing Study Comprehensive Report* released on August 29, 2023. The 463-page document is available at https://kffhealthnews.org/wp-content/uploads/sites/2/2023/08/Abt-Associates-CMS-NH-Staffing-Study_Final-Report_-Apndx_June_2023.pdf. *See also* Exclusive: CMS Study Sabotages Efforts to Bolster Nursing Home Staffing, Advocates Say - KFF Health NewsKFF Health News, ***Exhibit M*** submitted herewith.

78. The study was commissioned by CMS to identify the appropriate staffing levels, but the report's researchers made no specific recommendations and ultimately found there was ***"****no obvious plateau at which quality and safety are maximized or 'cliff' below which quality and safety steeply decline.*" Researchers also wrote that, "Recent literature underscores the relationship between nursing home staffing and quality outcomes... *However, it does not provide a clear evidence basis for setting a minimum staffing level*" (emphasis added).

79. Specifically, CAHCF requested that the Commissioner consider the new CMS-commissioned research findings that there is no one size fits all minimum staffing

ratio that will guarantee quality improvement … and that a "…total nursing staff requirement would ensure adequate overall staffing levels to meet the clinical and activities of daily living (ADL) tasks while *allowing nursing homes discretion in determining the staffing mix most appropriate for their population*." (emphasis added).

80. Further, in this recently released study, researchers also concluded that "additional staffing costs, estimated in the billions, could be a parallel barrier to implementation." Based on the staffing level scenarios the researchers examined, "the total costs could range from $1.5 to $6.8 billion annually depending on the structure and option."

81. The new study, begun in May 2022 and released in August 2023, is the most comprehensive evaluation of nursing home staffing ever conducted as it includes a comprehensive range of components, including formative activities, such as a literature review, and design study stakeholder input sessions, and qualitative activities, such as nursing home site visits across the nation, and quantitative activities, such analysis of state specific staffing requirements, cost and saving analysis, analysis of relationship of staffing with quality and safety and simulations of delayed/omitted clinical care. The scope and depth of this comprehensive CMS commissioned report sits in stark comparison to the cursory review supporting the DPH's direct care minimum staffing policies and procedures and proposed regulations.

Response to Request for Reconsideration

82. On September 29, 2023, DPH notified CAHCF that it deemed the Request for Reconsideration to be improper, declining to consider the Request. DPH's Response is appended hereto as ***Exhibit N***. This appeal followed.

AGGRIEVEMENT

83. CAHCF brings this appeal on behalf of its 151 member nursing home facilities that are directly impacted and harmed by the Declaratory Rulings. Each member would otherwise have standing in its own right to assert the claims and seek the relief set forth herein.

84. CAHCF is a trade association and advocacy organization whose purpose is to advocate on behalf of its member nursing homes. Pursuit of this appeal on behalf of its members falls squarely within CAHCF's purpose.

85. The claims and the relief requested herein do not require individual participation by CAHCF's members. While the Declaratory Rulings negatively impact each member of CAHCF and, if the relief sought is granted, all of CAHCF's members would benefit, pursuit by CAHCF of this appeal is both efficient and proper.

86. CAHCF, on behalf of its members, is aggrieved by the Declaratory Rulings because they violate Section 19a-563h of the General Statutes and CAHCF's rights thereunder.

87. CAHCF, on behalf of its members, is aggrieved by the Declaratory Rulings because their factual determinations are clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record.

88. CAHCF, on behalf of its members, is aggrieved by the Declaratory Rulings because they are arbitrary or capricious, or characterized by an abuse of discretion or a clearly unwarranted exercise of discretion.

89. For these reasons, CAHCF, acting on behalf of its members, has a specific personal and legal associational interest at stake that the Declaratory Rulings have specifically and injuriously affected.

LEGAL CLAIMS

COUNT I: DPH'S DECLARATORY RULINGS VIOLATE A STATUTORY PROVISION.

90. CAHCF incorporates Paragraphs 1-90 above, as if fully set forth herein.

91. Section 19a-563h of the General Statutes requires Connecticut nursing home facilities to establish minimum staffing level requirements of three hours of direct care per resident per day, increasing the minimum staffing levels from the prior 1.9 hours of direct care per resident per day.

92. Section 19a-563h of the General Statutes also requires DPH to adopt regulations requiring nursing homes to staff at levels consistent with the new mandate of three hours of direct care per resident per day. Section 19a-563h also states DPH may implement interim policies and procedures to administer the new statutory provisions pending adoption of the formal regulations.

93. The statute plainly states that DPH shall adopt regulations which set forth and implement the new three-hour minimum staffing level requirements to implement the statute; it does not state that DPH had the ability to allocate those hours between different levels of care providers between licensed nursing staff and nurse's aides, a concept that had been specifically rejected during the legislative process. The statute does not state that DPH can allocate those hours among different levels of care providers without regard to the cost of such allocation, or without regard to whether individual resident needs are adequately addressed by this allocation.

94. In the Declaratory Rulings, DPH misreads the scope of authority in the statutory mandate, claiming the General Assembly required DPH to adopt regulations specifically allocating those mandatory three hours of minimum staffing among levels of

care providers. No such mandate or authorization exists in the plain language of the statute.

95. As a result, the Declaratory Rulings violate Section 19a-563h by far exceeding the authorization to promulgate regulations and by imposing a mandatory allocation of the minimum staffing level hours between different levels of care providers, namely, between licensed nursing staff and nurse's aides.

96. The Declaratory Rulings should be vacated and reversed on this finding and the DPH policies and procedures requiring specific allocation of levels of staff should be vacated as a violation of Section 19a-563h.

97. This matter should be remanded to DPH with directions to issue new Declaratory Rulings consistent with CAHCF's requested rulings set forth herein.

COUNT II: DPH's DECLARATORY RULINGS ARE CLEARLY ERRONEOUS IN VIEW OF THE RELIABLE, PROBATIVE, AND SUBSTANTIAL EVIDENCE ON THE WHOLE RECORD, INCLUDING NEW EVIDENCE AFTER FILING OF PETITION.

98. CAHCF incorporates Paragraphs 1-98 above, as if fully set forth herein.

99. To the extent any question exists as to whether DPH has the authority to specifically allocate the minimum staffing level hours among different levels of care providers, based on the legislative history of Section 19a-563h, the General Assembly clearly intended that the increase in minimum staffing level requirements be done in a cost-effective manner and in a manner that allows consideration of the specific needs of nursing home residents at each facility.

100. With respect to budgetary considerations, DSS's response to the statute reflects this interpretation since DSS included in its budget only $500,000.00 to implement this new policy. This sum is substantially less than the estimated cost of specifically

allocating those hours among different levels of care providers, as set forth in the Fiscal Notes addressing the cost issue.

101. Since DPH issued its policies and procedures allocating those three hours between licensed nursing staff and nurse's aides, nursing homes have been forced to seek additional funding from DSS to comply with the new mandate.

102. The numbers are actually staggering: nursing homes have requested an additional $22.7million in funding for the current fiscal year alone in order to comply with DPH's allocation of staff to cover the three-hour minimum staffing requirements. To date, DSS has only been able to provide an additional $1 million in funding – less than 4% -- to cover the cost to nursing homes for compliance. As anticipated during the legislative history of Section 19a-563h, allocating those hours among specific levels of care providers would increase costs of care exponentially, which is precisely why the General Assembly eliminated specific allocations.

103. In addition, the statute and its legislative history reflect the intent of the General Assembly to give nursing homes the discretion on how to allocate those staffing hours among different levels of professionals, including licensed nursing staff and nurse's aides, to best meet the individual needs of residents at each facility.

104. Yet, in the Declaratory Rulings, DPH ignored the legislative history and purpose of the statute, claiming that the statute expressly authorized DPH to implement policies and procedures by which those three hours of direct care would be specifically allocated among the different levels of professionals – specifying precise hours for nursing staff and for nurse's aides – without regard to whether such allocation properly addressed the specific patient needs of residents in nursing home facilities.

105. Accordingly, the substantial evidence in the record as a whole does not support DPH's finding that the specific allocations in the policies and procedures are in accord with the legislative history and intent of Section 19a-563h.

106. As a result, it was clear error for DPH to find that the General Assembly intended DPH to specifically allocate the three hours of minimum staffing levels between licensed nursing staff and nurse's aides.

107. DPH's errors have resulted in nursing homes incurring tens of millions of dollars in costs to comply with DPH's specific allocation of care providers, rendering the policies and procedures an unreasonable unfunded mandate. DPH's errors also have removed any discretion among nursing home facilities to schedule staff based on the specific and individual needs of residents at each facility.

108. For these reasons, the Declaratory Rulings were clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record.

109. The Declaratory Rulings should be reversed on these findings.

110. This matter should be remanded to DPH with directions to issue new Declaratory Rulings consistent with CAHCF's requested rulings set forth herein.

COUNT III: DPH's DECLARATORY RULINGS ARE ARBITRARY OR CAPRICIOUS, OR CHARACTERIZED BY AN ABUSE OF DISCRETION OR A CLEARLY UNWARRANTED EXERCISE OF DISCRETION.

111. CAHCF incorporates Paragraphs 1-111 above, as if fully set forth herein.

112. Before posting the Notice of Intent, during industry communications, DPH led nursing homes to believe that changes in the Policies and Procedures would be minor when, in fact, the changes would increase costs to nursing homes by 60%.

113. DPH prepared the language in the Policies and Procedures on minimum staffing with little or no public input and no transparency with industry stakeholders.

114. DPH provided no data or studies or any other literature to support the required allocation of staffing in the new policy, particularly with respect to the increased reliance on nurse's aides. DPH failed to consider or review how the increased reliance on nurse's aides would impact the quality of care in nursing homes by requiring greater use of CNAs/nurse's aides in place of licensed nursing staff.

115. DPH has been unable to demonstrate how it arrived at the allocation numbers and has provided no rational basis for the allocations.

116. By departing from past custom and practice in these multiple ways, and by ignoring Section 19a-563h, DPH failed to act in a consistent, predictable, and reliable manner that allows CAHCF and its members to plan, manage their businesses, and provide safe and reliable care to their residents.

117. The Declaratory Rulings were arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion, and should be reversed as to the issues above.

WHEREFORE, Plaintiff Connecticut Association of Health Care Facilities, Inc. respectfully requests that this Court:

(i) Sustain this appeal;

(ii) Reverse, vacate, or remand DPH's Final Declaratory Rulings [Corrected], dated August 24, 2023, requiring DPH to issue new rulings that

a. nursing homes in Connecticut meet the minimum staffing level requirement of three (3.0) hours of direct care per resident per day under Conn. Gen. Stat. § 19a-563h with three (3.0) hours of total nursing and nurse's aide personnel time,

b. any regulations, policies and procedures promulgated by DPH with respect to minimum staffing level requirements which set specific minimum staffing levels for each category of nursing services (RNs, LPNs and/or CNAs) for those three (3.0) hours of direct care per resident per day would be in violation of the purpose and intent of Conn. Gen. Stat. § 19a-563h(a); and

(iii) Grant such other relief in law or in equity as is required or appropriate.

PLAINTIFF CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INC.

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EXHIBIT A

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
PUBLIC HEALTH HEARING OFFICE

IN RE: PETITION FOR DECLARATORY RULINGS CONCERNING MINIMUM STAFFING LEVELS REQUIRED UNDER CONN. GEN. STAT. § 19a-563h(a) AND THE VALIDITY OF REGULATIONS, POLICIES, AND PROCEDURES PROMULGATED BY THE STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

PETITIONER: CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INC.

DECLARATORY RULINGS

(Corrected)

By way of a Petition for Declaratory Rulings, dated February 28, 2023, Connecticut Association of Health Care Facilities, Inc. (the "Petitioner" or "CAHCF") requested the Department of Public Health ("DPH") to issue a declaratory ruling on the following:

(1) Under Conn. Gen. Stat. § 19a-563h(a), Connecticut nursing homes meet the statutory minimum staffing level requirement by providing the minimum of three (3.0) hours of direct care per resident per day with three (3.0) hours of total nursing and nurse's aide personnel time, as intended by the Connecticut General Assembly; and
(2) Regulations, policies and procedures promulgated by DPH with respect to minimum staffing level requirements that set specific minimum staffing levels for each category of nursing services (registered nurses ("RNs"), licensed practical nurses ("LPNs") and/or nurse's aide personnel ("CNAs")) for those three (3.0) hours of direct care per resident per day violate Conn. Gen. Stat. § 19a-563h(a).[1]

[1] DPH's policies and procedures and promulgated regulations do not differentiate between RNs and LPNs.

Subsequently, DPH advised the Petitioner that it would issue a Declaratory Ruling regarding the foregoing questions, pursuant to Conn. Gen. Stat. § 4-176(e), without holding a hearing. This declaratory ruling proceeding was conducted in accordance with the requirements of the Uniform Administrative Procedure Act, Conn. Gen. Stat. § 4-166 *et seq*.

DISCUSSION

A. DPH has Jurisdiction to Issue a Ruling in This Matter.

"A declaratory ruling is a ruling as to the validity of any regulation, or the applicability to specified circumstances of a provision of the general statutes, a regulation, or a final decision on a matter within the jurisdiction of the agency." *Bd. of Educ. of Town of Stafford v. State Bd. of Educ.*, 243 Conn. 772, 780 (1998) (quoting Conn. Gen. Stat. § 4-176(a)) (internal quotation marks omitted). In this case, DPH is ruling on the application of Conn. Gen. Stat. § 19a-563h to regulations and policies and procedures promulgated by DPH regarding minimum staffing levels in Connecticut nursing homes. Said statute, regulations, and policies and procedures are expressly within DPH's jurisdiction. Thus, DPH has jurisdiction to issue a declaratory ruling in this matter.

B. Background.

At the time of the enactment of Conn. Gen. Stat. § 19a-563h, minimum staffing levels for Connecticut nursing homes set forth in section 19-13-D8t(m) of the Regulations of Connecticut State Agencies provided as follows, in relevant part:

> (m) **Nursing staff:**
>
> (1) Each facility shall employ sufficient nurses and nurse's aides to provide appropriate care of patients housed in the facility 24 hours per day, seven days per week.
>
> (2) The number, qualifications, and experience of such personnel shall be sufficient to assure that each patient:

(A) receives treatment, therapies, medications and nourishments as prescribed in the patient care plan developed pursuant to subsection (o) (2) (I) of these regulations;
(B) is kept clean, comfortable and well groomed;
(C) is protected from accident, incident, infection, or other unusual occurrence.

(3) The facility's administrator and director of nurses shall meet at least once every 30 days in order to determine the number, experience and qualifications of staff necessary to comply with this section. . . .

(5) In no instance shall a chronic and convalescent nursing home have staff below the following standards:

(A) Licensed nursing personnel:

7 a.m. to 9 p.m.:	.47 hours per patient
9 p.m. to 7 a.m.:	.17 hours per patient

(B) Total nursing and nurse's aide personnel:

7 a.m. to 9 p.m.:	1.40 hours per patient
9 p.m. to 7 a.m.:	.50 hours per patient . . . .

Regs., Conn. State Agencies § 19-13-D8t(m).

Under this regulation, Connecticut nursing homes were required to staff total licensed nursing and nurse's aide personnel at a level of 1.9 hours per patient per day without specifically allocating this time between licensed nurses and nurse's aides.

In an effort to increase minimum staffing levels, during the January 2021 legislative session Senate Bill 1030 (S.B. 1030) was introduced with the following language:

> Sec. 13 (NEW) (*Effective October 1, 2021*) . . . (b) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for nursing homes of at least four and one-tenth hours of direct care per resident, including three and three-quarter hours of care by a registered nurse, fifty-four hundredth hours of care by a licensed practical nurse and two and eighty-one hundredth hours of care by a certified nurse's assistant . . . .

S.B. 1030, Original Draft.

The original draft increased the total number of direct care staff hours from 1.9 hours per day to 4.1 hours per day per resident while requiring a specific number of hours

for each licensure category. After the introduction of the original draft, an amendment to S.B. 1030 was adopted, which, among making other changes, eliminated the specific licensure categories and hours associated with those categories and reduced the total number of direct care staff hours from 4.1 hours per day to 3.0 hours per day per resident. Specifically, the Amendment stated:

> Sec. 10 (NEW) (*Effective October 1, 2021*) (a) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for nursing homes of three hours of direct care per resident per day. . . .

Amended S.B. 1030. This language was codified in Conn. Gen. Stat. § 19a-563h.

Thereafter, in accordance with the Conn. Gen. Stat. § 19a-563h(b), DPH implemented policies and procedures necessary to administer the provisions of the statute while in the process of adopting such policies and procedures as regulations. The policies and procedures established a minimum staffing level of 3.0 hours per resident and allocated these hours with specific minimum staffing hours for licensed nursing personnel and nurse's aide personnel. Those policies and procedures state in relevant part:

(m) **Nursing staff:**

> **(**1) For purposes of this subsection, "direct care staff" shall mean licensed nursing personnel and certified nurse aides that are engaged in direct health care services, that include but are not limited to, personal care services for residents in nursing homes.
> (2) Each facility shall employ sufficient nurses and nurse's aides to provide appropriate care of residents housed in the facility twenty-four hours per day, seven days per week, which shall include a minimum direct care staffing level of three hours of direct care per resident per day.
> (3) The number, qualifications, and experience of such personnel shall be sufficient to assure that each [patient] resident: (A) receives treatment, therapies, medications and nourishments as prescribed in the patient care plan developed pursuant to subsection (o) (2) (I) of these regulations; (B) is kept clean, comfortable and well groomed; and (C) is protected from accident, incident, infection, or other unusual occurrence.
> (4) The facility's administrator and director of nurses shall meet at least once

every thirty days in order to determine the number, experience and qualifications of staff necessary to comply with this section. . . .
(6) In no instance shall a chronic and convalescent nursing home, or rest home with nursing supervision have staff below the following standards:
(A) Licensed nursing personnel:
7 a.m. to 9 p.m.: .57 hours per resident

9 p.m. to 7 a.m.: .27 hours per resident
(B) Nurse's aide personnel:

7 a.m. to 9 p.m.: 1.60 hours per resident

9 p.m. to 7 a.m.: .56 hours per resident . . . .

The Petitioner seeks a declaratory ruling that (1) nursing homes comply with Conn. Gen. Stat. § 19a-563h(a) by providing three hours of direct care per resident per day without adhering to the allocation of time between nursing personnel and nurse's aide personnel in the policies and procedures, and (2) said allocation in the policies and procedures violates Conn. Gen. Stat. § 19a-563h.

C. DPH's Policies and Procedures Do Not Violate Conn. Gen. Stat. § 19a-563h.

The Petitioner asserts that the General Assembly, in enacting the provision in Conn. Gen. Stat. § 19a-563h(a) that DPH establish minimum staffing level requirements for nursing homes of three hours of direct care per resident per day, restricted DPH's authority to set this level to an aggregate total of nursing and nurse's aide personnel time. The Petitioner asserts that because the statute does not itself set separate minimum staffing levels for licensed nursing and nurse's aide personnel, DPH is not authorized by the statute to do so. In essence, the Petitioner's position is that the legislative intent was to allow nursing homes, as opposed to DPH, to determine this allocation.

The Petitioner acknowledges that to determine the General Assembly's intention, one must first look to the plain meaning of the statute. Conn. Gen. Stat. § 1-2z states: "The meaning of a statute shall, in the first instance, be ascertained from the text of the statute itself and its relationship to other statutes. If, after examining such text and considering such relationship, the meaning of such text is plain and unambiguous and does not yield absurd or unworkable results, extratextual evidence of the meaning of the statute shall not be considered."

The Petitioner asserts that the plain meaning of Conn. Gen. Stat. § 19a-563h(a) directs that nursing homes, rather than DPH, determine the mix of nursing personnel and nurse's aides because the statute does not expressly mandate minimum hours for any subset thereof and any staffing ratios among nurses and nurse's aides.

To the contrary, subsection (a) of Conn. Gen. Stat. § 19a-563h requires "***the Department of Public Health***" to "establish minimum staffing level requirements for nursing homes of three hours of direct care per resident per day . . . ." Conn. Gen. Stat. § 19a-563h(a) (emphasis added). The language of the statute is clear and plain, and in it there is no indication that the General Assembly intended for DPH to defer to the regulated facilities to determine the allocation of hours of direct care among nurses and nurse's aides. Statutory construction cannot be used to "read into a statute what is not there," nor can it ignore a statute's express terms. *Anderson v. Ludgin*, 175 Conn. 545, 558 (1978).

Where Conn. Gen. Stat. § 19a-563h(a)(1) directs DPH to "establish" staffing levels, subsection (a)(2) directs DPH to "modify" the staffing level requirements for social work and recreational staff of nursing homes. In 2021, when Conn. Gen. Stat. § 19a-563h was enacted, DPH regulations provided specific ratios of hours of social work staff and recreational staff to nursing home beds per week. *See* Regs., Conn. State Agencies § 19-13-D8t(r)(3) (recreational

therapy); § 19-13-D8t(s)(5) (social work). These regulations did not specify a staffing ratio for nurse's aides; instead, the regulations set forth the minimum combined hours of nursing personnel and nurse's aides per patient for two 14-hour shifts. *See* Regs., Conn. State Agencies § 19-13-D8t(m)(5). It is clear that the General Assembly was aware of the existing regulations because in 2022 it amended the statute and directed DPH to modify[2] the existing regulations' ratios for social work staff and recreational staff. *See* Public Act 22-58. In contrast, with knowledge that the nurse's aides and nursing personnel were combined in the existing regulation, the General Assembly directed DPH not merely to modify the staffing ratio, but to *establish* the staffing level – that is "to bring into existence"[3] such levels – which is consistent with DPH's creation of staffing ratios for each type of provider – nurse's aides and licensed nursing personnel.

The term "level" is not defined in the Conn. Gen. Stat. § 19a-563h. "If a statute or regulation does not sufficiently define a term, it is appropriate to look to the common understanding of the term as expressed in a dictionary." *S. New Eng. Tel. Co. v. Cashman,* 283 Conn. 644, 656 (2007) (internal quotation marks omitted). Merriam Webster defines the noun "level" as "a position in a scale or rank". *Level*, Merriam-Webster Dictionary, https://www.merriam-webster.com (August 18, 2023). In drafting the policies and procedures, and regulations, DPH appropriately construed the term "level" as the licensure category of staff providing care to residents in nursing homes (i.e., the rank of licensure).

[2] Merriam Webster defines "modify" as "to change". *Modify,* Merriam-Webster Dictionary, https://www.merriam-webster.com (August 18, 2023).
[3] Merriam Webster defines "establish" as "to bring into existence". *Establish,* Merriam-Webster Dictionary, https://www.merriam-webster.com (August 18, 2023).

While Conn. Gen. Stat. § 19a-563h(a) does not specifically state the levels of staff licensure to be allocated among the 3.0 hours, it is reasonable and appropriate for DPH to establish the staffing licensure levels in Connecticut nursing homes. As the Connecticut Supreme Court has held, "a legislative gap is not equivalent to a lack of authority for the agency to act. . . . Rather, the power of an administrative agency to administer a . . . program *necessarily requires the formulation of policy and the making of rules to fill any gap left, implicitly or explicitly,* by the legislature." *Crandle v. Connecticut State Emps. Ret. Comm'n*, 342 Conn. 67, 79 (2022) (citation and internal quotation marks omitted; emphasis in original). *See also State v. Stoddard*, 126 Conn. 623, 628 (1940) ("A Legislature, in creating a law complete in itself and designed to accomplish a particular purpose, may expressly authorize an administrative agency to fill up the details by prescribing rules and regulations for the operation and enforcement of the law.").

Where the General Assembly has clearly delegated power, "the modern tendency is liberal in approving delegation under broad regulatory standards so as to facilitate the operational functions of administrative boards or commissions." *Salmon Brook Convalescent Home v. Comm. on Hosp. & Health Care,* 177 Conn. 356, 368 (1979). Here, in enacting Conn. Gen. Stat. § 19a-563(h), the General Assembly clearly delegated authority to DPH by explicitly charging it with establishing the staffing levels in nursing homes. While the Petitioner interprets the failure of the General Assembly to specify the staffing levels as supporting the conclusion that, rather than empowering the regulatory authority to do so, it intended to allow the regulated entity to set their own staffing requirements, the plain meaning of Conn. Gen. Stat. § 19a-563h(a) belies such interpretation.

Also of note are related statutes that existed at the time Conn. Gen. Stat. § 19a-563h was enacted. For example, pursuant to Conn. Gen. Stat. § 19a-562g, nursing homes are required to separately calculate and post on a daily basis the total number and hours per shift of both nurses and nurse's aides providing direct patient care to residents of the nursing home. In addition, the facility is to post the minimum number of nursing home facility staff per shift responsible for providing direct patient care to residents of the nursing home facility that is required by Connecticut regulations, as well as the phone number and website for reporting suspected violations of these regulations. Conn. Gen. Stat. § 19a-562g(c). The Petitioner's position that Conn. Gen. Stat. § 19a-563h precludes DPH from establishing separate staffing ratios for nurse's aides and licensed nursing personnel is incongruous with the categorical requirements in Conn. Gen. Stat. § 19a-562g, particularly where separately calculating and posting the hours of direct care provided by nurse's aides and nursing personnel enables residents and their families to effectively raise concerns about inadequate staffing.

It also is noteworthy that the General Assembly had the opportunity to revisit Conn. Gen. Stat. § 19a-563h during the 2023 legislative session, but it failed to change its provisions. The challenged policies and procedures were posted on the Secretary of State's e-regulations website on February 21, 2023. Thereafter, the General Assembly's Aging Committee held hearings on and passed Senate Bill 1026, which would have amended Conn. Gen. Stat. § 19a-563h by providing among other changes specific staffing ratios for nurse's aides and for each type of nurse, similar to that in the original version of S.B. 1030. Despite being aware that DPH's presently challenged policies and procedures[4] established specific staffing ratios, the Committee took no action to alter Conn. Gen. Stat. § 19a-563h to conform to the Petitioner's restrictive

[4] The Office of Fiscal Analysis Fiscal Note for the bill makes specific reference to the new staffing ratios. *See* https://www.cga.ct.gov/2023/FN/PDF/2023SB-01026-R000081-FN.PDF.

construction. To the contrary, the Committee voted in favor of expanding the staffing hours as reflected in the bill. Further, despite the budgetary impact associated with implementing the policies and procedures' staffing ratios, as identified by the Petitioner, the General Assembly took no action to provide financial relief to the nursing homes.

Our Supreme Court consistently has held that when the response to an agency's interpretation of a statute is legislative silence, said silence should be construed as legislative concurrence in that interpretation. *See, e.g., Velez v. Comm'r of Lab.*, 306 Conn. 475, 492 (2012) (Court assumes that if legislature disagreed with an agency's interpretation of a statute, it would have taken corrective action); *Comm'n on Hum. Rts. & Opportunities v. Sullivan Assocs.*, 250 Conn. 763, 783 (1999) ("The legislature is presumed to be aware of the interpretation of a statute and . . . its subsequent nonaction may be understood as a validation of that interpretation."); *Connecticut Light & Power Co. v. Pub. Utils. Control Auth.*, 176 Conn. 191, 199–200 (1978) ("That legislative concurrence is "presumptive evidence" of the correctness of the administrative interpretation."). The General Assembly, being fully aware of DPH's policies and procedures, had the opportunity last session to amend or modify Conn. Gen. Stat. § 19a-563h. It failed to do so, and its silence reasonably may be construed as legislative concurrence with DPH's interpretation of the statute.

C. The Legislative History Does Not Demonstrate Intent to Deprive DPH of the Authority to Determine Minimum Staffing Levels.

The Petitioner argues that the testimony before legislative committees supports its position that DPH does not have authority to promulgate regulations or policies and procedures that specifically allocate nurse's aides and nursing personnel hours. However, as discussed above, where the language of a statute is unambiguous, it is inappropriate to consider its legislative history, including any offered testimony. *See* Conn. Gen. Stat. § 1-2z ("If, after

examining [a statute's] text and considering [its relationship to other statutes], the meaning of such text is plain and unambiguous and does not yield absurd or unworkable results, extratextual evidence of the meaning of the statute shall not be considered."). DPH's construction of the statute, which permits DPH to establish staffing levels for both licensed nursing personnel and nurse's aides, does not result in absurd or unworkable results; rather, DPH's construction of Conn. Gen. Stat. § 19a-563h not only derives from the clear language of the statute itself, but is consistent with the statutory scheme as a whole, as described above.

Furthermore, even if it were appropriate to consider extratextual evidence here, the Petitioner's characterization of the testimony in support of its position is incorrect.

DPH's original regulations pertaining to nursing home staffing levels provided both the measure for the appropriate level of staffing and a minimum, or floor, to the staffing to be provided in all circumstances. Section 19-13-D8t(m)(1) of the Regulations provided that the proper level of staffing was based upon the needs of the patients: "Each facility shall employ sufficient nurses and nurse's aides to provide appropriate care of patients housed in the facility 24 hours per day, seven days per week." Subsection (m)(2) provided: "The number, qualifications, and experience of such personnel shall be sufficient to assure that each patient: (A) receives treatment, therapies, medications and nourishments as prescribed in the patient care plan developed pursuant to subsection (o) (2) (I) of these regulations; (B) is kept clean, comfortable and well groomed; (C) is protected from accident, incident, infection, or other unusual occurrence." Subsection (m)(3) provided that the facility was required to perform a monthly assessment to make these determinations." In addition, subsection (m)(6) set a floor of minimum hours for nursing personnel and the combined total hours of nursing personnel and nurse's aides.

In its Petition, CAHCF refers to written testimony provided in March 2021 by DPH Acting Commissioner Dr. Deidre S. Gifford regarding the original S.B. 1030 to support its position that DPH opposed original S.B. 1030 and was in favor of nursing homes determining minimum staffing levels to meet resident needs. The written testimony stated in relevant part:

> The Department recommends all facilities have adequate staffing with the appropriate competencies and skills sets to provide nursing and related services, based on a facility assessment, to assure resident safety and attain or maintain the highest practicable level of physical, mental, and psychosocial well-being of each resident. The facility assessment uses individual resident assessments and plans of care to ascertain the number, type of diagnosis, and acuity of the facility's resident population. In the nursing home setting, regulations require that the administrator and director of nursing meet monthly to determine adequate staffing levels using a tool based on the acuity of their current resident census.

(Petition, Exhibit 2)

The Petitioner misinterprets Dr. Gifford's testimony as opposition to original S.B. 1030. Rather than speaking in opposition, Dr. Gifford testified that staffing should be adequate to meet resident needs – a position consistent with the existing original regulations described above. Dr. Gifford did not speak against the setting of minimum levels as reflected in the policies and procedures, but instead she testified that, beyond any minimum levels, proper staffing levels should be dictated by resident needs. When referencing the "facility assessment", Dr. Gifford was speaking to the facility assessment driving the ***appropriate*** level of staffing rather than the ***minimum*** level of staffing. *See* Regs., Conn. State Agencies § 19-13-D8t(m)(4). Stated simply, a nursing home should provide greater staffing levels than those minimums set by DPH based on resident needs. This does not mean that staffing level decisions should be left solely to the nursing home. Nor does it mean that DPH is restricted from setting separate minimum staffing levels for licensed nursing personnel and nurse's aides. It simply means that staffing levels for

each provider should be based on the needs of the resident subject to the minimum staffing levels set by DPH.

In fact, Dr. Gifford's position is *incorporated* in the challenged policies promulgated by DPH in subsections (m)(2)-(4), and, therefore, the challenged policies and procedures are consistent with Dr. Gifford's testimony and should not be construed otherwise.

The Petitioner also points to Dr. Gifford's testimony which it characterizes as declining to support the original version of S.B. 1030. However, Dr. Gifford stated, "we probably are **aligned on the intent** and want to just engage you a little bit more on the specifics and how it would be implemented **and supported**." (Petition Exhibit 5). When reading her testimony as a whole, it is clear that Dr. Gifford supported the original bill's express intention to set minimum hours per resident for each level of health care professional, but also wanted to "engage" on the bill's implementation.

Dr. Gifford's testimony in favor of the bill does not support the contention that the General Assembly intended to have nursing homes rather than DPH determine what minimum level of staffing for licensed nursing personnel and nurse's aides is required under Conn. Gen. Stat. § 19a-563h.

D. The Fiscal Notes Are Not Evidence of the General Assembly's Intent.

In its Petition, CAHCF argues that "the General Assembly's allocation of $500,000 to support the increased costs of Section 19a-563h further supports the General Assembly's *intent* to increase the total hours of direct care *without* imposing the mandated staffing ratios . . . ." (Emphasis added.) (Petition, p. 11) CAHCF cites a Fiscal Note prepared by the Office of Fiscal Analysis ("OFA") as the basis for its claim.

Just as it is inappropriate to consider Dr. Gifford's testimony, it likewise is inappropriate to consider the Fiscal Note in construing Conn. Gen. Stat. § 19a-563h. *See* Conn. Gen. Stat. § 1-2z. It is nevertheless worth noting that the Fiscal Note explicitly *disclaims* that it represents the General Assembly's intent: "The preceding Fiscal Impact Statement . . . does not represent the intent of the General Assembly or either chamber thereof for any purpose." (Petitioner Exhibit 8, p. 2) And in fact, our Supreme Court has held that fiscal notes authored by the OFA "'are not, in and of themselves, evidence of legislative intent . . . .'" *State v. Bischoff,* 337 Conn. 739, 760–61 (2021) (quoting *Butts v. Bysiewicz*, 298 Conn. 665, 688 n.22 (2010)). Therefore, CAHCF's reliance upon the Fiscal Note to establish the General Assembly's intent is misplaced.[5]

The Petitioner argues that the budget allocations made by the General Assembly and projections by the Department of Social Services are not consistent with interpreting Conn. Gen. Stat. § 19a-563h as permitting DPH to allocate specific hours per resident separately for nurse's aides and licensed nursing personnel. The Petitioner asserts that because the allocation and projections were not sufficient to support the costs of said allocation, the General Assembly could not have intended to authorize DPH to allocate specific hours.

However, the fact that budget allocations or projections do not match changes in the regulatory requirements for nursing homes is not determinative of legislative intent. To the contrary, the General Assembly has anticipated and acknowledged that regulatory requirements will take precedence over such projections. For example, Conn. Gen. Stat. § 17b-340 provides in relevant part:

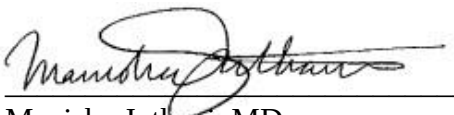
[5] The Fiscal Note in relevant part states: "The actual cost depends on the number and type of staff required." Given the acknowledged uncertainty of how staffing levels will be determined, the Fiscal Note is not relevant in resolving the question of whether the General Assembly intended the determination of the number or type of staff to be left to the nursing homes rather than DPH.

> If changes in federal or state laws, regulations or standards adopted subsequent to June 30, 1985, result in increased costs or expenditures in an amount exceeding one-half of one per cent of allowable costs for the most recent cost reporting year, the commissioner [of the Department of Social Services] shall adjust rates and provide payment for any such increased reasonable costs or expenditures within a reasonable period of time retroactive to the date of enforcement.

This statute clearly demonstrates that the General Assembly acknowledges that budget allocations and projections are merely estimates and not restraints on the implementation of statutory directions to the state regulatory agencies.

CONCLUSION

DPH appropriately differentiated between licensed nursing personnel and nurse's aide personnel when it drafted its policies and procedures and promulgated regulations to implement the purposes of Conn. Gen. Stat. § 19a-563h. Therefore, under the Statute, Connecticut nursing homes ***do not*** meet the statutory minimum staffing level requirement by providing a minimum of three (3.0) hours of direct care per resident per day with three (3.0) hours of total nursing and nurse's aide personnel time. Furthermore, the policies and procedures and regulations promulgated by DPH that set specific minimum staffing hours for nurses and nurse's aides for those three (3.0) hours of direct care per resident per day ***do not*** violate Conn. Gen. Stat. § 19a-563h(a).



Manisha Juthani, MD
Commissioner

08/24/2023
Date

EXHIBIT B

General Assembly

Raised Bill No. 1030

January Session, 2021

LCO No. **4720**

Referred to Committee on PUBLIC HEALTH

Introduced by:
(PH)

AN ACT CONCERNING LONG-TERM CARE FACILITIES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective October 1, 2021*) (a) As used in this section and sections 2 to 12, inclusive, of this act, "long-term care facility" means a nursing home, as defined in section 19a-521 of the general statutes, a residential care home, as defined in section 19a-521 of the general statutes, a home health agency, as defined in section 19a-490 of the general statutes, an assisted living services agency, as defined in section 19a-490 of the general statutes, an intermediate care facility for individuals with intellectual disability, as described in 42 USC 1396d(d), except any such facility operated by a Department of Developmental Services' program subject to background checks pursuant to section 17a-227a of the general statutes, a chronic disease hospital, as defined in section 19a-550 of the general statutes, or an agency providing hospice care which is licensed to provide such care by the Department of Public Health or certified to provide such care pursuant to 42 USC 1395x.

(b) Each long-term care facility shall employ a full-time infection prevention and control specialist who shall be responsible for the

following:

(1) Ongoing training of all employees of the long-term care facility on infection prevention and control using multiple training methods, including, but not limited to, in-person training and the provision of written materials in English and Spanish;

(2) The inclusion of information regarding infection prevention and control in the documentation that the long-term care facility provides to residents regarding their rights while in the facility;

(3) Participation as a member of the long-term care facility's infection prevention and control committee; and

(4) The provision of training on infection prevention and control methods to supplemental or replacement staff of the long-term care facility in the event an infectious disease outbreak or other situation reduces the facility's staffing levels.

Sec. 2. (NEW) (*Effective October 1, 2021*) The administrative head of each long-term care facility shall participate in the development of the emergency plan of operations of the political subdivision of this state in which it is located which is required pursuant to the Intrastate Mutual Aid Compact made and entered into under section 28-22a of the general statutes.

Sec. 3. (NEW) (*Effective October 1, 2021*) (a) Not later than six months after the termination of a public health emergency declared by the Governor pursuant to section 19a-131a of the general statutes, (1) the Department of Public Health shall have and maintain at least a three-month stockpile of personal protective equipment, including, but not limited to, gowns, masks, full-face shields, goggles and disposable gloves as a barrier against infectious materials, for use by long-term care facilities, and (2) the administrative head of each long-term care facility shall ensure that the facility acquires from the department and maintains at least a three-month supply of personal protective equipment for its staff. The administrative head of each long-term care

facility shall ensure that the personal protective equipment is of various sizes based on the needs of the facility's staff. The personal protective equipment (A) shall not be shared amongst the facility's staff, and (B) may only be reused in accordance with the strategies to optimize personal protective equipment supplies in health care settings published by the National Centers for Disease Control and Prevention. The administrative head of each long-term care facility shall hold quarterly fittings of his or her staff for N95 masks or higher rated masks certified by the National Institute for Occupational Safety and Health.

(b) On or before January 1, 2022, the Department of Emergency Management and Homeland Security, in consultation with the Department of Public Health, shall establish a process to evaluate, provide feedback on, approve and distribute personal protective equipment for use by long-term care facilities in a public health emergency.

Sec. 4. (NEW) (*Effective October 1, 2021*) The administrative head of each long-term care facility shall ensure that there is at least one staff member during each shift who is licensed or certified to start an intravenous line.

Sec. 5. (NEW) (*Effective October 1, 2021*) Each long-term care facility's infection prevention and control committee shall meet (1) at least monthly, and (2) during an outbreak of an infectious disease, daily, provided daily meetings do not cause a disruption to the operations of the facility, in which case the committee shall meet at least weekly. The prevention and control committee shall be responsible for establishing infection prevention and control protocols for the long-term care facility. Not less than biannually and after every outbreak of an infectious disease in the facility, the prevention and control committee shall evaluate the implementation and analyze the outcome of such protocols.

Sec. 6. (NEW) (*Effective October 1, 2021*) On or before January 1, 2022, every administrator and supervisor of a long-term care facility shall

complete the Nursing Home Infection Preventionist Training course produced by the National Centers for Disease Control and Prevention in collaboration with the Centers for Medicare and Medicaid Services.

Sec. 7. (NEW) (*Effective October 1, 2021*) Each long-term care facility shall, during an outbreak of an infectious disease, test staff and residents of the facility for the infectious disease at a frequency determined by the Department of Public Health as appropriate based on the circumstances surrounding the outbreak and the impact of testing on controlling the outbreak.

Sec. 8. (NEW) (*Effective October 1, 2021*) On or before January 1, 2022, the administrative head of each long-term care facility shall facilitate the establishment of a family council to encourage and support open communication between the facility and each resident's family members and friends. As used in this section, "family council" means an independent, self-determining group of the family members and friends of a long-term care facility's residents that is geared to meeting the needs and interests of the residents and their family members and friends.

Sec. 9. (NEW) (*Effective October 1, 2021*) (a) On or before January 1, 2022, the administrative head of each long-term care facility shall (1) ensure that each resident's care plan addresses (A) the resident's potential for isolation, ability to interact with family members and friends and risk for depression, (B) how the resident's social and emotional needs will be met, and (C) measures to ensure that the resident has regular opportunities for in-person and virtual visitation, (2) disclose the facility's visitation protocols, any changes to such protocols and any other information relevant to visitation in a form and manner that is easily accessible to residents and their family members and friends, (3) advise residents and their family members and friends of their right to seek redress with the Office of the Long-Term Care Ombudsman under section 17a-410 of the general statutes when the resident or a family member or friend of the resident believes the facility has not complied with its visitation protocols, and (4) establish a timeline by which the facility will ensure the safe and prompt

reinstatement of visitation following the termination of the public health emergency declared by the Governor in response to the COVID-19 pandemic and a program to monitor compliance with such timeline. As used in this section "COVID-19" means the respiratory disease designated by the World Health Organization on February 11, 2020, as coronavirus 2019, and any related mutation thereof recognized by the World Health Organization as a communicable respiratory disease.

(b) On or before January 1, 2021, the administrative head of each long-term care facility shall ensure that its staff is educated regarding (1) best practices for addressing the social, emotional and mental health needs of residents, and (2) all components of person-centered care.

Sec. 10. (NEW) (*Effective October 1, 2021*) On or before January 1, 2022, the Department of Public Health shall establish an essential caregiver program for implementation by each long-term care facility. The program shall (1) set forth visitation requirements for essential caregivers of long-term care facility residents, and (2) require the same infection prevention and control training and testing standards for an essential caregiver of a resident of the facility that are required for the facility's staff. As used in this section "essential caregiver" means a person deemed critical, as determined by a long-term care facility, to the daily care and emotional well-being of a resident of the facility.

Sec. 11. (*Effective from passage*) On or before October 1, 2021, the Public Health Preparedness Advisory Committee established pursuant to section 19a-131g of the general statutes shall amend the plan for emergency responses to a public health emergency prepared pursuant to said section to include a plan for emergency responses to a public health emergency in relation to long-term care facilities and providers of community-based services to residents of such facilities.

Sec. 12. (NEW) (*Effective from passage*) (a) On and after July 1, 2021, each long-term care facility shall permit a resident to use a communication device, including a cellular phone, tablet or computer, in his or her room, in accordance with the requirements established

under subsection (b) of this section, to remain connected with their family members and friends and to facilitate the participation of a resident's family caregiver as a member of the resident's care team.

(b) On or before June 30, 2021, the Commissioner of Public Health shall (1) establish requirements regarding the use of communication devices by long-term care facility residents under subsection (a) of this section to ensure the privacy of other long-term care facility residents, and (2) communicate such requirements to each long-term care facility.

Sec. 13. (NEW) (*Effective October 1, 2021*) (a) As used in this section, "nursing home" means (1) any chronic and convalescent nursing home or any rest home with nursing supervision that provides nursing supervision under a medical director twenty-four hours per day, or (2) any chronic and convalescent nursing home that provides skilled nursing care under medical supervision and direction to carry out nonsurgical treatment and dietary procedures for chronic diseases, convalescent stages, acute diseases or injuries.

(b) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for nursing homes of at least four and one-tenth hours of direct care per resident, including three and three-quarter hours of care by a registered nurse, fifty-four hundredth hours of care by a licensed practical nurse and two and eighty-one hundredth hours of care by a certified nurse's assistant, (2) modify staffing level requirements for social work and recreational staff of nursing homes such that the requirements are lower than the current requirements, as deemed appropriate by the Commissioner of Public Health, and (3) eliminate the distinction between a chronic and convalescent nursing home and a rest home, as defined in section 19a-490 of the general statutes, as such distinction relates to nursing supervision, for purposes of establishing a single, minimum direct staffing level requirement for all nursing homes.

(c) On and after January 1, 2022, each nursing home shall offer its staff the option to work twelve-hour shifts.

(d) The commissioner shall adopt regulations in accordance with the provisions of chapter 54 of the general statutes that set forth nursing home staffing level requirements to implement the provisions of this section.

Sec. 14. (NEW) (*Effective October 1, 2021*) (a) For purposes of this section: (1) "Ombudsman" means the Office of the Long-Term Care Ombudsman established pursuant to section 17a-405 of the general statutes; (2) "electronic monitoring" means the placement and use of an electronic monitoring device by a nonverbal resident or his or her resident representative in the resident's room or private living unit in accordance with this section; (3) "electronic monitoring device" means a camera or other device that captures, records or broadcasts audio, video, or both, and may offer two-way communication over the Internet that is placed in a nonverbal resident's room or private living unit and is used to monitor the nonverbal resident or activities in the room or private living unit; (4) "nursing home facility" has the same meaning as provided in section 19a-490 of the general statutes; (5) "nonverbal resident" means a resident of a nursing home facility who is unable to verbally communicate due to physical or mental conditions, including, but not limited to, Alzheimer's disease and dementia; and (6) "resident representative" means (A) a court-appointed guardian, (B) a health care representative appointed pursuant to section 19a-575a of the general statutes, or (C) a person who is not an agent of the nursing home facility and who is designated in a written document signed by the nonverbal resident and included in the resident's records on file with the nursing home facility.

(b) A nonverbal resident or his or her resident representative may install an electronic monitoring device in the resident's room or private living unit provided: (1) The purchase, installation, maintenance, operation and removal of the device is at the expense of the resident, (2) the resident and any roommate of the resident, or the respective resident representatives, sign a written consent form pursuant to subsection (c) of this section, (3) the resident or his or her resident representative places a clear and conspicuous note on the door of the room or private

living unit that the room or private living area is subject to electronic monitoring, and (4) the consent form is filed with the nursing home facility not less than seven days before installation of the electronic monitoring device except as provided in subsection (e) of this section.

(c) No electronic monitoring device shall be installed in a nonverbal resident's room or living unit unless the resident and any roommate of the resident, or a resident representative, has signed a consent form that includes, but is not limited to:

(1) (A) The signed consent of the nonverbal resident and any roommate of the resident; or (B) the signed consent of a resident representative of the nonverbal resident or roommate if the nonverbal resident or roommate lacks the physical or mental capacity to sign the form. If a resident representative signs the consent form, the form must document the following:

(i) The date the nonverbal resident or any roommate was asked if the resident or roommate wants electronic monitoring to be conducted;

(ii) Who was present when the nonverbal resident or roommate was asked if he or she consented to electronic monitoring;

(iii) An acknowledgment that the nonverbal resident or roommate did not affirmatively object to electronic monitoring; and

(iv) The source of the authority allowing the resident representative of the nonverbal resident or roommate to sign the consent form on behalf of the nonverbal roommate or resident.

(2) A waiver of liability for the nursing home facility for any breach of privacy involving the nonverbal resident's use of an electronic monitoring device, unless such breach of privacy occurred because of unauthorized use of the device or a recording made by the device by nursing home facility staff.

(3) The type of electronic monitoring device to be used.

(4) A list of conditions or restrictions that the nonverbal resident or any roommate of the resident may elect to place on the use of the electronic monitoring device, including, but not limited to: (A) Prohibiting audio recording, (B) prohibiting video recording, (C) prohibiting broadcasting of audio or video, (D) turning off the electronic monitoring device or blocking the visual recording component of the electronic monitoring device for the duration of an exam or procedure by a health care professional, (E) turning off the electronic monitoring device or blocking the visual recording component of the electronic monitoring device while the nonverbal resident or any roommate of the resident is dressing or bathing, and (F) turning off the electronic monitoring device for the duration of a visit with a spiritual advisor, ombudsman, attorney, financial planner, intimate partner or other visitor to the nonverbal resident or roommate of the resident.

(5) An acknowledgment that the nonverbal resident, roommate or the respective resident representative shall be responsible for operating the electronic monitoring device in accordance with the conditions and restrictions listed in subdivision (4) of this subsection unless the resident, roommate or the respective resident representative have signed a written agreement with the nursing home facility under which nursing home facility staff operate the electronic monitoring device for this purpose. Such agreement may contain a waiver of liability for the nursing home facility related to the operation of the device by nursing home facility staff.

(6) A statement of the circumstances under which a recording may be disseminated.

(7) A signature box for documenting that the nonverbal resident or roommate of the resident, or the respective resident representative, has consented to electronic monitoring or withdrawn consent.

(d) The ombudsman, within available appropriations, shall make available on the ombudsman's Internet web site a downloadable copy of a standard form containing all of the provisions required under

subsection (c) of this section. Nursing home facilities shall (1) make the consent form available to nonverbal residents and inform such residents and the respective resident representatives of their option to conduct electronic monitoring of their rooms or private living units, (2) maintain a copy of the consent form in the nonverbal resident's records, and (3) place a notice in a conspicuous place near the entry to the nursing home facility stating that some rooms and living areas may be subject to electronic monitoring.

(e) Notwithstanding subdivision (4) of subsection (b) of this section, a nonverbal resident or his or her resident representative may install an electronic monitoring device without submitting the consent form to a nursing home facility if: (1) The nonverbal resident or the resident representative (A) reasonably fears retaliation against the nonverbal resident by the nursing home facility for recording or reporting alleged abuse or neglect of the resident by nursing home facility staff, (B) submits a completed consent form to the ombudsman, and (C) submits a report to the ombudsman, the Commissioner of Social Services, the Commissioner of Public Health or police, with evidence from an electronic monitoring device that suspected abuse or neglect of the nonverbal resident has occurred; (2) (A) the nursing home facility has failed to respond for more than two business days to a written communication from the nonverbal resident or his or her resident representative about a concern that prompted the resident's desire for installation of an electronic monitoring device, and (B) the nonverbal resident or his or her resident representative has submitted a consent form to the ombudsman; or (3) (A) the nonverbal resident or his or her resident representative has already submitted a report to the ombudsman, Commissioner of Social Services, Commissioner of Public Health or police regarding concerns about the nonverbal resident's safety or well-being that prompted the resident's desire for electronic monitoring, and (B) the nonverbal resident or his or her resident representative has submitted a consent form to the ombudsman.

(f) If a nonverbal resident is conducting electronic monitoring and a new roommate moves into the room or living unit, the nonverbal

resident shall cease use of the electronic monitoring device unless and until the new roommate signs the consent form and the nonverbal resident or his or her resident representative files the completed form with the roommate's consent to electronic monitoring with the nursing home facility. If any roommate of a nonverbal resident wishing to use electronic monitoring refuses to sign the consent form, the nursing home facility shall reasonably accommodate the nonverbal resident's request to move into a private room or a room with a roommate who has agreed to consent to such monitoring, if available, not later than thirty days after the request. The nonverbal resident requesting the accommodation shall pay any difference in price if the new room is more costly than the resident's previous room.

(g) Subject to applicable rules of evidence and procedure, any video or audio recording created through electronic monitoring under this section may be admitted into evidence in a civil, criminal or administrative proceeding.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2021*	New section
Sec. 2	*October 1, 2021*	New section
Sec. 3	*October 1, 2021*	New section
Sec. 4	*October 1, 2021*	New section
Sec. 5	*October 1, 2021*	New section
Sec. 6	*October 1, 2021*	New section
Sec. 7	*October 1, 2021*	New section
Sec. 8	*October 1, 2021*	New section
Sec. 9	*October 1, 2021*	New section
Sec. 10	*October 1, 2021*	New section
Sec. 11	*from passage*	New section
Sec. 12	*from passage*	New section
Sec. 13	*October 1, 2021*	New section
Sec. 14	*October 1, 2021*	New section

Statement of Purpose:

To implement the recommendations of the Nursing Home and Assisted Living Oversight Working Group regarding long-term care facilities and make other revisions to the long-term care facility statutes.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]

EXHIBIT C

Connecticut Department of Public Health

Testimony Presented Before the Public Health Committee

March 17, 2021

Acting Commissioner Deidre S. Gifford, MD, MPH
860-509-7101

Senate Bill 1030, An Act Concerning Long Term Care Facilities

The Department of Public Health (DPH) provides the following information regarding Senate Bill 1030, which will implement the recommendations for long-term care facilities of the Nursing Home and Assisted Living Oversight Working Group in addition to revising specific long-term care facility statutes. Thank you for the opportunity to testify on this important bill.

It was our honor to serve the Nursing Home and Assisted Living Oversight Working Group, which has been jointly led by members of the General Assembly and representatives of the Department of Public Health, the Department of Social Services, and the Office of Policy and Management. We are grateful to the leaders and members of each of the subcommittees for the significant time and attention they have devoted to the work of the group.

Section 1 defines a long-term care facility as a nursing home (NH), residential care home (RCH), home health agency (HHA), assisted living services agency (ALSA), intermediate care facility for individuals with intellectual disabilities (ICF/IID), chronic disease hospital, or hospice agency for the purposes of Sections 2-12 of the bill. Since ICF/IID facilities are licensed by the Department of Developmental Services (DDS), DPH would defer to DDS for comments regarding such facilities.

This section also requires a long-term care facility, as defined in the bill, to employ a full-time infection preventionist. Over the past year, the Department has had several findings in these healthcare settings, with the vast majority in nursing homes, that relate to infection control. We often found that the individual in charge of infection prevention was handling multiple positions or working part time and was unable to provide the support needed during the COVID-19 pandemic. The Department supports this initiative in the nursing home setting. It is important to note that ICF/IIDs, RCHs, HHAs, ALSAs, and agencies providing hospice care are not medical models and they do not have the same staffing levels as a NH or chronic disease hospital. The requirement for a full-time infection preventionist may not be appropriate in these settings. However, these facilities should have policies and procedures in place to address infection prevention and control measures. Additionally, the Department would be happy to collaborate with DDS on reviewing appropriate procedures for ICF/IID facilities.

Section 2 requires the administrative head of each long-term care facility to participate in the development of the emergency plan of operations of the Intrastate Mutual Aid Compact pursuant to C.G.S. Section 28-22a. The Department is supportive of the concept outlined in this section and requests further discussion with the proponents of the bill and the Department of Emergency Services and Public Protection to determine the best approach for long-term care facilities to be involved in emergency response planning. For your information, the Centers for Medicare & Medicaid Services (CMS) issued a Final Rule in September 2016 to establish national emergency preparedness requirements to ensure adequate planning for both natural and man-made disasters, and coordination with state, and local emergency preparedness systems. Guidance on these requirements was issued to impacted entities. The federal rule applies to 17 healthcare provider and supplier types, including long-term care facilities. Each provider has its own set of regulations and conditions or requirements for certification. Such healthcare providers and suppliers must be in compliance with the federal emergency preparedness regulations to participate in the Medicare and Medicaid programs.

Section 3 requires DPH to have and maintain at least a three-month stockpile of personal protective equipment (PPE) not later than six months after the termination of a public health emergency. Additionally, it requires the administrative head of each long-term care facility to acquire from the Department and maintain a three-month supply of PPE. Lastly, it requires the administrator for each long-term care facility to fit test their staff for N95 masks on a quarterly basis.

Occupational Safety and Health Administration (OSHA) standards require that persons who use N95 equipment be fit tested on a yearly basis. The Department recommends that long term care facilities adopt OSHA standards, which includes a plan to ensure these individuals are appropriately fit tested. During the pandemic, DPH was provided federal funds, which were used to provide PPE to facilities. There were some instances of PPE shortages and mitigation strategies involving multiple use of PPE had to be put in place. These strategies were recommended by the Centers for Disease Control and Prevention (CDC).

DPH recognizes the importance of PPE while caring for a patient with an infectious disease to protect the health and safety of the workers. During the pandemic, the Commissioner put forward a commissioner's order that required nursing homes to have a reserve stockpile of enough PPE and hand sanitizer to manage an outbreak of twenty percent of the facility's average daily census for a thirty-day period. Facilities were required to fill out an online attestation acknowledging they had implemented the requirements of the commissioner's order. The Department notes that PPE has expiration dates and also may be unused if an outbreak is not taking place. Additionally, PPE is stored in large boxes, which means it may be difficult for a facility to find storage. It is the facility's responsibility, however, to ensure they have enough PPE to appropriately protect their staff on a day to day basis. The Department agrees that a comprehensive strategy needs to be in place during extraordinary circumstances such as the COVID-19 pandemic. However, the Department does not think that legislation is needed; often

such a statute may diminish our ability to be flexible in responding to an emergency that is ever evolving.

Section 4 requires each long-term care facility to have at least one staff person per shift that can start an intravenous line. While well-intentioned, this requirement may be onerous for a long-term care facility as defined, with the exception of a chronic disease hospital. These settings do not use intravenous lines frequently enough to retain their skills in starting and maintaining intravenous lines. Most of these facilities enter into a contract for this service with an infusion company to care for their residents with intravenous lines. Additionally, an order would have to be given from an independent practitioner to prescribe what medication would be delivered through an intravenous line. DPH would welcome a discussion with the proponents of the bill about the requirements in Section 4 as there are many factors to consider in determining how an intravenous line should be introduced to a patient.

Section 5 requires each long-term care facility to have an infection prevention and control committee that meets monthly; and daily during an outbreak. This committee will be responsible for establishing, implementing and reviewing infection prevention and control protocols for the facility. The Department is supportive of measures that can be put in place to mitigate the impact of an infectious disease outbreak in a facility.

Section 6 requires every administrator and supervisor of a long-term care facility to complete the Nursing Home Infection Preventionist training course produced by CDC in collaboration with CMS. The Department is supportive of training in infection control and prevention core activities to reduce the spread of an infectious disease for administrators and supervisors of long-term care facilities. During the COVID-19 pandemic, the Department identified that when the infection preventionist was out sick or on leave, they needed other personnel to fill in for their duties. These individuals included the administrator and the director of nursing. However, we think the CDC course may not provide the most appropriate training. In lieu of the CDC training course, the Department recommends inserting language that would require a nursing home administrator to have a minimum of four contact hours of continuing education on "infection control and the prevention of infections associated with antimicrobial use, including antimicrobial resistant infections" within subsection (b) of C.G.S. Section 19a-515. These CEU's would allow the administrator to continually train on the best practices for infection prevention and control.

Section 7 requires DPH to provide each long-term care facility with a frequency for testing staff and residents during an outbreak of an infectious disease. Such frequency will be based on the circumstances surrounding the outbreak and the impact of testing on controlling the outbreak. During an outbreak, the Department may look to CDC for guidance on best practices in the treatment and mitigation of an infectious disease, which may include testing. Some infectious diseases do not require regular testing. As an outbreak evolves, guidance is modified to appropriately adapt to the situation. DPH already provides guidance to long-term care facilities

that reflects recommendations supported by CDC pertaining to appropriate prevention and control approaches to mitigating an infectious disease. The Department recommends not moving forward with this section of the bill.

Section 8 requires each long-term care facility to establish a "family council" to enhance communication between the facility, its residents and their families or representatives. The Department supports this effort to facilitate communication between facilities, families and residents as this communication is imperative to the well-being of the resident. We learned during the COVID-19 pandemic, when visitation was restricted, that virtual and other means of communication with representatives and family was crucial.

Section 9 requires each long-term care facility to ensure that a resident's care plan addresses provisions related to the health and well-being of the resident, to include social and emotional needs being met and that visitation by any means is provided. Additionally, the bill requires the facility to establish a timeline for the reinstatement of visitation following the termination of a public health emergency as declared by the Governor. Nursing homes are required to follow CMS guidance relating to visitation, which is revised as new information arises. While visitation is critically important to a long-term care facility resident's physical, mental and psychosocial well-being, it is also important to balance visitation with control measures to reduce the transmission of an infectious disease. The Department's goal is to ensure the safety of the residents and staff, however, balancing this at all times with resident rights.

Section 10 requires the Department to establish an essential caregiver program for implementation by each long-term care facility, which includes standards for infection prevention and control training and testing. DPH is currently working with the State Long Term Care Ombudsman and other stakeholders on developing an essential support person program.

Section 11 requires the Department's Public Health Preparedness Advisory Committee to amend the plan for emergency responses to a public health emergency to include a plan for long-term care facilities and providers of community-based services. The Department supports this recommendation and will work with our Office of Public Health Preparedness to review the Public Health Emergency Response Plan to determine the best way to incorporate long-term facility emergency planning during a disaster. The aforementioned CMS Final Rule establishes national emergency preparedness requirements through CMS to ensure adequate planning for both natural and man-made disasters as well as coordination with state and local emergency preparedness systems. Guidance on these requirements was issued to impacted entities. The federal rule applies to 17 healthcare provider and supplier types, including long-term care facilities. Each provider has its own set of regulations and conditions or requirements for certification. Such healthcare providers and suppliers must be in compliance with the federal emergency preparedness regulations to participate in the Medicare and Medicaid programs.

Section 12 requires each long-term care facility to permit a resident to use a communication device to connect with family members and friends and to facilitate the participation of a resident's family caregiver as a member of the resident's care team. This section also requires DPH to establish requirements for the use of these communication devices by July 1, 2021. The Department supports efforts that connect the resident with their family, friends and representatives. In May 2020, the Department, through the use of Civil Money Penalty Reinvestment Funds, provided each of Connecticut's nursing homes with at least two electronic devices, which will support this effort. The Department respectfully requests that the timeline to develop policies regarding the use of communication devices be extended until December 2021.

Section 13 requires DPH to establish minimum staffing level requirements for nursing homes and eliminates the distinction between a chronic and convalescent nursing home (CCNH) and a rest home with nursing services (RHNS) to ensure a minimum staffing level requirement for all nursing homes. The Department recommends all facilities have adequate staffing with the appropriate competencies and skill sets to provide nursing and related services, based on a facility assessment, to assure resident safety and attain or maintain the highest practicable level of physical, mental, and psychosocial well-being of each resident. The facility assessment uses individual resident assessments and plans of care to ascertain the number, type of diagnoses, and acuity of the facility's resident population. In the nursing home setting, regulations require that the administrator and director of nursing meet monthly to determine adequate staffing levels using a tool based on the acuity of their current resident census.

Thank you for your consideration of this information. DPH encourages committee members to reach out with any questions.

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EXHIBIT D

CAHCF/CCAL
Connecticut Association of Health Care Facilities
Connecticut Center for Assisted Living

March 17, 2021

Written testimony of Matthew V. Barrett, President/CEO of the Connecticut Association of Health Care Facilities and the Connecticut Center For Assisted Living (CAHCF/CCAL)

Good afternoon Senator Abrams, Representative Steinberg, and to the distinguished members of the Public Health Committee. My name is Matt Barrett. I am the President and CEO of the Connecticut Association of Health Care Facilities (CAHCF), our state's trade association and advocacy organization of one-hundred and sixty skilled nursing facilities and assisted living communities. Thank you for this opportunity to submit testimony concerning **S.B. No. 1030 (RAISED) AN ACT CONCERNING LONG-TERM CARE FACILITIES.**

As the committee further deliberates on the legislation, CAHCF/CCAL has the following recommendations for your consideration.

Infection Prevention and Control Specialist (Sec 1)

CAHCF/CCAL agrees in elevating that status of Infection Preventionists (IPs) in our Connecticut nursing homes. Effective infection prevention and control programs can decrease infection rates and health care acquired infections, improve attention to hand hygiene and transmission-based precautions, improve employee health, and reduce hospitalizations and adverse events among nursing home residents.

While most Connecticut nursing homes have designated full time IPs, others have one or more part-time, specially trained IPs with additional duties. Prior to COVID-19, nursing homes already experienced a nationwide shortage of registered nurses (RNs) and other challenges in recruiting qualified staff, including IPs. The pandemic has only exacerbated these workforce challenges. The increased demand for resources and dedicated, specifically trained IPs, which are most often fulfilled by an RN, remain a challenge, especially for smaller nursing homes. For these reasons, we recommend:

• The amount of time required for an IP be adjusted based on each facility's bed count, demographics of the facility's surrounding area, individual factors contributing to infection control risk levels, and flexibility for smaller facilities.

• A phased-in requirement to give nursing homes time to recruit and train the new IPs.

We also recommend that infection prevention training requirements have the flexibility to be met by training materials prepared by CAHCF/CCAL's national affiliate, the American Health Care Association (AHCA), include funds to cover any training costs, and that the intent of training language be clarified to mean the training applies to the administrator and RN supervisor.

Personal Protective Equipment Requirements (Sec 3)

CAHCF/CCAL appreciates that the proposed PPE stockpile requirements seek to establish a statewide stockpile acquired and managed by the Department of Public Health equal to a three months PPE supply level for use by nursing homes. We would like to point out that storing a three-month supply of PPE on site at the facility will present great challenge for many nursing homes with insufficient storage capabilities. Therefore, we are asking that the legislation provide the option for the PPE to be earmarked for a specific nursing home, but actually housed in a central storage site managed by the state and accessed as needed by the nursing homes. We also recommend that quarterly N-95 fit testing be available for new employees and that an annual fit testing be the standard for existing employees according to OSHA standards.

Licensed and Certified Staff to Start Intravenous Lines (Sec. 4)

CAHCF/CCAL is asking the committee to recognize that due to RN staffing shortages, most nursing homes must contract with a long-term pharmacy to secure qualified staff to start intravenous lines. Accordingly, we recommend that the language be modified to include IV starts by contracted staff, including a 24-hour remote coverage by the external contracted service provider, in addition to staff employed by the nursing homes.

Establishment of a Family Council (Section 8)

We recommend that this provision include a cross reference to federal rules concerning the establishment of family councils to assure consistency and compliance with federal requirements.

Increased Nursing Home Staffing (Sec 13)

As reported by the Staffing Levels Subcommittee of the Nursing Home and Assisted Living Oversight Work Group (NHALOWG) in January 2021: "Adequate numbers of qualified, trained, appropriately compensated, and caring staff are integral to support the needs of nursing home residents in a holistic and person-centered manner." There is no disagreement from CAHCF/CCAL on the policy goals expressed by the subcommittee. Further, the subcommittee acknowledged that achieving this result necessarily involves diverse strategies, including, but not limited to: Establishing a daily minimum staffing ratio of at least 4.1 hours of direct care per resident, composed of: ▪ .75 hours Registered Nurse ▪ .54 hours Licensed Practical Nurse ▪ 2.81 hours Certified Nurse Assistant. To help inform the implications of increasing staffing in this manner, CAHCF/CCAL obtained the support of the *Center for Health Policy Evaluation in Long Term Care* ("The Center") to provide a framework for estimating the costs of increasing minimum staffing ratios in Connecticut nursing homes. The full report is attached.

In this initial and preliminary framework, the *Center* reviewed creating minimum nurse staffing to resident thresholds in nursing homes (RN = 0.75, LPN = 0.54, and CNA = 2.81) for a Total Nursing Staffing of 4.1. In the report, the Center characterized the facilities currently below this threshold and calculated the number of additional staff and labor costs needed to achieve the proposed minimum staffing. They used staffing levels collected by the Center for

Medicare and Medicaid Census (CMS) from nursing home payroll data. To estimate total labor costs, they used average state labor costs, fringe benefits, and payroll tax rates. Further, the Center observed.

> Based on Q3 2020 staffing data, 181 (88.7%) of nursing homes in Connecticut are below the proposed minimum staffing threshold. The analysis was repeated using pre-COVID Q4 2019 staffing census data. Under pre-COVID conditions, the number of nursing homes below the minimum staffing threshold rose to 199 (97.5%). A big driver for this increase was a higher census pre-COVID. The average Connecticut nursing home census in Q4 2019 was 104 compared to 86 in Q3 2020. This is a 17% decline, which exceeds the national average decline of 14%. On average, Connecticut nursing homes below the staffing threshold are larger and have more Medicaid residents than the others. Their November 2020 Five-Star ratings were on average lower.
>
> For Connecticut to implement minimum staffing ratios, we estimate it will require between 1,793-3,364 FTEs and cost $140.9-$273.9 million dollars. The exact figure will depend on resident census.
> To get the current 181 nursing homes above the proposed minimum staffing threshold, 1,793 FTEs would be needed statewide at a total annual cost of $140.9 million, including fringe benefits and payroll taxes. CNAs make up most of the needed FTEs (1,426) and cost ($95.0 million). This assumes census stays the same as it is now, which is much lower than before the COVID pandemic.
> To estimate the costs when census increases, our simulation was repeated using pre-COVID-19 Q4 2019 PBJ staffing census data. In this analysis, the number of nursing homes below the minimum threshold rose to 199 (97.5%). Also increasing were the number of needed FTEs (3,364) and costs ($273.9 million) to meet the minimum staffing.

As census returns over the next 18 months, we can anticipate these costs to increase further, necessitating accompanying reimbursement increases.

- CAHCF/CCAL supports the effort to ensure adequate staffing at all nursing homes and to compensate all nursing home caregivers and employees at a level that recognizes their value. However, we favor a focus on elevating the status and importance of long-term care staff through recruitment and retention strategies and providing long underfunded nursing homes with the financial resources needed to address these staffing issues. A significant state and federal investment will be required to increase staffing requirements, minimum staffing ratios, or minimum wages during or after the pandemic when there are limited trained individuals to fill the positions and not enough resources to cover additional, unfunded costs.

- We do not support a recommendation to establish a minimum percentage of reimbursement to be spent on staffing without further study of the issue in the context of planned shifts in reimbursement structure to an acuity-based system and more thorough consideration of potential impacts of such a requirement. Finally, nursing homes should be given the flexibility on where to direct the percentage of staffing resources to RNs, LPNs and CNAs to address the specific care needs of the individual nursing homes.

Essential Support Caregiver or Support and Video Monitoring and Technology

CAHCF/CCAL will to continue to review and offer our recommendations on the use of technology to facility visitation and monitoring in nursing homes to both the Public and Health Committee and the Aging Committee, where legislation has now been favorably reported (HB 6552) on this matter, and is also addressed in **Section 12 and 14 of SB 1030**. Similarly, we will continue to review and offer our recommendations concerning an Essential Support Person initiative to the Public Health Committee and the Human Services Committee where legislation is under consideration (HB 6634) and is also addressed in **Section 10 of SB 1030**. At this time, because visitation in nursing homes unrestricted outside of a public health emergency, any provisions for essential caregivers or essential support persons should apply only when visitation is actually restricted by federal or state rules. Finally, additional training requirements on nursing homes, if adopted, to implement an essential caregiver or support person initiative must include additional funds for this purpose.

Thank you again for this opportunity to testify on the bill as drafted. I would be happy to answer any questions you may have.

For additional information, contact: Matthew V. Barrett, mbarrett@cahcf.org or 860-290-9424.

EXHIBIT E

Testimony to the Public Health Committee

Presented by Mag Morelli, President of LeadingAge Connecticut

March 17, 2021

Regarding

Senate Bill 1030, An Act Concerning Long Term Care Facilities

Good afternoon Senator Abrams, Representative Steinberg and members of the Public Health Committee. My name is Mag Morelli and I am the President of LeadingAge Connecticut, a statewide membership association representing not-for-profit provider organizations serving older adults across the continuum of aging services, including not-for-profit skilled nursing facilities, residential care homes, home health care agencies, hospice agencies, adult day centers, assisted living communities, senior housing and life plan communities. As an association, we encourage the state and federal government to value aging by investing in quality.

On behalf of LeadingAge Connecticut I am pleased to provide testimony on *Senate Bill 1030, An Act Concerning Long Term Care Facilities.*

Over the past year, the aging services field has been at the center of the global Covid-19 pandemic. Covid-19 is a virus that has targeted the very people we serve. As such, our member organizations have been uniquely impacted by the pandemic, unlike any other health care provider sector. And we are proud of our efforts. LeadingAge Connecticut members have faced this pandemic head on and continue to do so as we protect and compassionately care for the most vulnerable older adults in our state.

The bill before you today reflects many of the recommendations that came out of the Nursing Home and Assisted Living Oversight Working Group (NHALOWG). The NHALOWG was formed to make recommendations on proposed legislation for the 2021 session addressing lessons learned from COVID-19, based upon the Mathematica final report (A Study of the COVID-19 Outbreak and Response in Connecticut Long-Term Care Facilities) and other related information, concerning structural challenges in the operation and infrastructure of nursing homes and assisted living facilities; and changes needed to meet the demands of any future pandemic.

LeadingAge Connecticut was represented on NHALOWG and actively participated in the four subcommittees. While we support many of the recommendations that resulted from the valuable work done by NHALOWG, we do disagree with elements of some of them. Today's hearing provides us the opportunity to present our perspective, opinion and alternative language for

those sections of the bill and allows us to offer our assistance to the Committee as you work on this and other bills related to aging services.

Our first request is that the Committee consider adding the recommendations related to the NHALOWG's Subcommittee on Infrastructure and Capital Improvements into this bill. We have linked that subcommittee's report and recommendations to our testimony here and specifically, we would ask for the Committee's support of the following financing and funding options to enable necessary maintenance and improvements in the nursing home physical plant:

- Establishment of a state backed loan guarantee program,
- Establishment of a forgivable loan program for nursing homes,
- Establishment of a long-term bonding or direct lending program.

Our specific comments on Senate Bill 1030 are as follows:

Section 1

This bill begins by stating that Sections 1 through 12, if passed, would apply not only to nursing homes, but also to six other licensed settings including assisted living service agencies, residential care homes, intermediate care facilities for individuals with intellectual disability, chronic disease hospitals, home health care agencies, and hospice agencies. Each type of provider listed is unique in their service delivery and is regulated through separate state and/or federal laws and regulations. **We do not believe that all of the sections of this bill should apply to all of these settings and we will point this out as we go through each section of the bill.** (*Please note that we will not provide any comment on the relevance of the proposed bill to the intermediate care facility for individuals with intellectual disability setting as we do not represent that category of provider.)*

Subsection 1b would require that a full-time *infection prevention and control specialist* be employed by providers in each of the seven categories of licensed entities listed in Section 1a. An *infection preventionist* is a position defined and required by the federal Centers for Medicare and Medicaid (CMS) for all nursing homes and for which an on-line training course was established by CMS in collaboration with the Centers for Disease Control (CDC). The course is approximately 19 hours long, is made up of 23 modules and submodules, and is focused on the nursing home setting.

CMS has required the infection preventionist position in nursing homes since 2019. Currently CMS requires the infection preventionist to work at least part-time at the facility, but we understand that this requirement is under review in light of the pandemic. DPH has asked that each nursing home have an infection preventionist on staff for 32 hours per week and has advised that this function can be shared by two part-time individuals. **We have voiced our request to DPH that the infection preventionist hours be scaled to the size of the facility and that the individual be allowed to serve other functions within the building such as staff development**. We ask that the Committee consider this request.

While the specific position of infection preventionist is defined and required on the federal level for a nursing home, the other settings included in this proposal are not included in that CMS requirement. Similar to nursing homes, chronic disease hospitals as well as home health care, hospice and assisted living service agencies are all required to address infection control and prevention by state and federal regulation. **We do not think it is necessary to impose the specific infection preventionist position onto those provider entities.**

Regarding the residential care home, while licensed by the Department of Public Health, this is not a health care setting and therefore this full-time clinical position is not appropriate or practicable.

Section 2

We do not support this proposal which would require each of these licensed healthcare entities to participate in the actual *development* (line 32) of their municipal emergency operations plans. This is not their responsibility. We do agree, however, that the healthcare entities should inform the town or city emergency manager in the community where they are located of their own emergency preparedness plans and participate in ongoing emergency preparedness efforts in their community.

Section 3

Nursing homes are currently required through a DPH Commissioner's Order to stockpile a 30-day supply of personal protective equipment (PPE). The increase to a 90-day stockpiled supply raises the concern of adequate storage space in already space challenged nursing home floor plans. The nursing home would need to store this 90-day stockpile in addition to the operational supply of PPE that is being stored for daily use. This would be the same concern for the other provider entities included in this bill.

- **We request clarity** for the provision that seems to require the provider entities to purchase their PPE from the Department for Public Health. (Lines 44-47)
- **We do not understand** why the bill would require quarterly fit testing of N95 masks (line 55) when annual fit testing is what is the current federal requirement. This appears to be an unnecessary utilization of resources.
- While the early, severe shortages of PPE are now behind us, there continues to be sporadic shortages of various types and sizes of PPE in the market place. **We would hope that these types of situations would be recognized within the stockpiling requirement.**

Section 4

We oppose this section of the bill that would require that every provider listed in Section 1a be able to ensure that a licensed health care professional (in most cases that would be a registered nurse), who is certified to initiate an intravenous line, is scheduled on every shift. We cannot support this requirement because we simply do not understand why it is being proposed and what gap in long term care it is attempting to address.

While there is always a registered nurse on duty in Connecticut nursing homes, and technically the start of an intravenous line is within their licensed scope of practice, there is also a

competency standard that requires a continuous practice of this licensed function. The nursing home setting does not see the volume of intravenous therapy that would support this continuous practice. Rather, most nursing homes contract with a professional service to initiate intravenous therapy when and if it is needed. However, most nursing homes never have to provide this service, and those that do, specialize in it. Again, we do not understand why this requirement is being proposed and absent a logical reason, we cannot support it.

Regarding the other providers in this bill, assisted living service agencies are not staffed to the degree of nursing homes, and they would need to add a significant number of registered nurses to their schedule if they were to meet this requirement. Home care and hospice agencies which choose to provide IV therapy would be staffed appropriately to provide this service and this additional requirement would be unnecessary. Residential care homes are not a health care setting and therefore this requirement is not applicable or practicable.

Section 5

Regarding nursing homes, the Public Health Code requires that each facility have an infection control committee that meets quarterly. This section of the bill would require that this committee meet at least monthly and daily during an outbreak. This is more specific than the current federal requirements for nursing homes and we do not feel that it is necessary. The nursing home conducts daily infection control clinical surveillance under the guidance and direction of the director of nursing, medical director and infection preventionist. The quarterly meeting of the full committee is inclusive of this team and other medical and nursing staff, as well as consultants. **The nursing homes are of the opinion that a quarterly meeting schedule for the formal infection control committee is a sufficient minimum requirement to address the infection control needs of the facility** and that the frequency can be increased when necessary.

This specific committee is not currently a public health code requirement for the other health care providers addressed in the bill and is inappropriate for the residential care home setting.

Section 6

We have concerns regarding several aspects of this section. First, the mandated training course is specific to nursing homes, yet it would apply to all of the provider entities listed in the bill. It is not appropriate to require nursing home specific training of non-nursing home providers.

Second, we request that this section be clarified to specify exactly who is expected to take the course as the term “supervisor” is very broad and could be applied to several staff members throughout the nursing home. This specific course is currently a 19-hour, 23-module course that is designed for a clinically trained person. This would not be the appropriate training course for all levels of supervisor within the facility.

Finally, if we assume that the intent is to apply this section just to the nursing home setting, **we would suggest that instead of prescribing the specific training course within the statute, that the Committee rely upon the infection preventionist to determine the appropriate training for the nursing home staff members.** Section 1a of this bill would place the responsibility for ongoing

training of all employees of the facility on the infection preventionist. We would propose that the responsibility for selecting the appropriate training material should remain with the infection preventionist.

Section 7

The availability of testing was a pivotal milestone in the fight against the Covid-19 virus. Ensuring that the Department of Public Health has a role in determining the frequency and appropriateness of testing ensures that this statutory requirement remains timely and relevant.

Section 8

Specifically addressing the nursing home setting, these settings must adhere to federal OBRA regulations which currently allow for family councils to be established and require that nursing homes provide an advisor or liaison to the council, as well as meeting space and other assistance if requested. We believe the federal guidelines were designed to promote the independence of the council and we further believe the OBRA regulations to be sufficient for the nursing home setting. **We are also happy to work with our members to ensure that families are aware of the opportunity.**

We are concerned that if a nursing home or any other provider included in this bill is *mandated* to establish a family council (line 90: "…shall facilitate the establishment…"), that they would then have a statutory obligation to create an entity that families may not be interested in participating in; indeed, some of our members have found that to be the case. Family participation is something that the provider cannot force, and therefore we would oppose the mandated aspect of this section. While a provider may be required to assist upon request and even encourage the establishment of such a council, it should not be required to force its establishment.

Section 9

Again, it appears that this section is specifically addressing the nursing home setting. As such, we would agree that addressing a resident's psychosocial needs as outlined in lines 97 through 107 is appropriate, **but we request that the words "seek redress with" in line 108 be replaced with the word "contact."** Residents and families are encouraged to contact the Office of the Long-Term Care Ombudsman for guidance and advocacy, but there is not a mechanism to seek *redress* through that office.

We also request that the wording addressing reinstatement of visitation in lines 111 – 119 be removed as this references a federal restriction specific to the Covid-19 pandemic that was placed on nursing homes and will hopefully be outdated by the January 1, 2022 deadline in the bill.

Section 10

We have been supportive of the establishment of an essential caregiver or essential support person program that can be activated during a public health emergency when visitation to a long-term care facility is restricted. It is our understanding that this program would be most applicable to the nursing home setting.

Section 11
We support this section.

Section 12
We have been involved in discussions with the Aging Committee on another, similar legislative proposal regarding the use of communication technology specifically within the nursing home setting. **We reference that because we strongly support the need for privacy provisions for the use of communication devices for visitation as articulated in this proposal (lines 148 – 152);** the current Aging Committee bill does not contain privacy provisions related to the use of technology for virtual visitation. We would encourage the inclusion of this requirement in any bill focused on the use of communication technology in a long-term care setting.

This section of the bill may be more appropriate for the nursing home, chronic disease hospital and residential care setting where residents reside within a communal setting. For persons receiving care from an assisted living service agency or home health care agency, they would be residing in their own homes and would not need the protections afforded by this section of the bill.

Section 13
LeadingAge Connecticut understands the interest in raising the minimum nursing home staffing requirements that are currently listed in the Public Health Code for licensed and certified nursing staff. We do, however, want to reassure the Committee that both the Public Health Code and federal oversight regulations currently require nursing homes **to staff at a level that meets the needs of residents**. These same regulations authorize the Department of Public Health to assess penalties in certain cases when facilities fall short of staffing requirements and fail to employ sufficient staff to meet resident needs.

This bill proposes 4.1 hours of direct care per resident day minimum, **but it also proposes specific ratios per licensure category within that overall direct care minimum and we cannot support those specific ratios** (Lines 163 -166). To mandate specific ratios of CNA, RN and LPN within an overall minimum staffing level goes against the concept of flexing your staffing to meet the needs of the resident and flies in the face of our new acuity-based reimbursement system which is expected to be implemented later this year. These specific ratios* are based on a 20-year-old national study that does not recognize this states' 24 hour registered nurse requirement nor our strong use of the LPN in our nursing homes. More importantly, of the approximately sixty nursing homes that currently staff above a 4.1 hours per patient day, most would need to reduce the hours of licensed RN and LPN direct care staff (not administrative staff) in order to hire additional CNAs to meet those internal ratios. *(*We note that we believe there is a drafting error in the printing of these ratios and that they are intended to propose .75 hours of care by a registered nurse.)*

Nursing care is important. The direct care provided to a nursing home resident is not just personal care. Residents also receive direct nursing care such as medication administration and

treatments as well as nursing assessments. Nursing care must be provided by a registered nurse (RN) or licensed practical nurse (LPN). In fact, only a registered nurse is authorized to perform the actual nursing assessment; an LPN can examine the resident and provide information to the registered nurse, but the actual assessment must be done by the registered nurse. Nursing assessments are important, and required, components of the resident's overall care. Assessments determine the individualized care plan and must be conducted whenever there is a significant change of condition, and when required to be updated under state and federal requirements. Some nursing homes have chosen to staff nursing positions with more highly qualified registered nurses. Nursing homes that provide a strong level of direct registered nursing care are to be commended, not discounted, and we strongly object to any minimum staffing levels that disregard the importance of direct resident care that is provided by a registered nurse.

A very important issue that must be addressed is the Medicaid reimbursement with regard to nursing home staffing. Quality nursing home providers staff to meet the needs of their residents and many homes are staffing near or above the proposed 4.1 hours of direct care per resident day, but the Medicaid reimbursement rate does not cover the cost of this higher staffing. The vast majority of nursing homes that show high levels of staffing are also showing significant differentials between what the state Medicaid system is supposed to pay them according to their costs – and what the Medicaid system is actually paying them. **Very simply, they are not being reimbursed for their staffing costs.** As a result, we have a reimbursement system that is vastly underfunding the cost of staffing – at a time when the state is planning to transition to a staffing dependent acuity-based rate system – and without a plan to increase the funding. **We therefore urge the Committee to insist that any legislation implemented to raise the minimum staffing levels also must address the need to fully fund the reimbursement system.**

We would also be remiss if we did not raise our concern regarding the ability to recruit and retain an aging services workforce that can meet the needs and demands of our aging population. **We ask that the Committee support efforts to enhance the long-term services and supports workforce through expanded training opportunities, increased funding for reimbursement rates, and other efforts aimed at attracting and retaining workforce talent within the field of aging services**. Workforce competition has intensified with the increase in the minimum wage and recruitment efforts in the field of aging services have been dramatically impacted by the pandemic. **We need a long-term investment in aging services provider rates to assist providers with recruitment and retention of a strong and skilled workforce that is urgently needed as our state rapidly ages.**

This section of the bill also proposes a requirement for the Department of Public Health to modify staffing levels for social work and recreational staff of nursing homes (lines 167 – 169. We believe the intent may be to raise the levels, but as written would lower the required levels; we believe that this must be a drafting error. We agree that social work and recreational staff are critical to the overall resident experience within a nursing home. These positions, however, have never been categorized as direct care by the state and as such, have not received previously

legislated wage enhancements and other resources that have been directed to that category of the workforce. We are pleased to see these important services recognized.

This section of the bill also proposed to eliminate the Rest Home with Nursing Supervision (RHNS) level of care licensure (lines 170 -174). This is a licensure category defined in the Public Health Code and designed to care for a lower acuity level of resident. While most of these beds were converted many years ago to the higher licensure level of Chronic and Convalescent Nursing Home (CCNH), there are currently ten nursing homes that have beds licensed in this category. Three of the ten are non-profit, LeadingAge Connecticut members who have both levels of licensure within their buildings.

We must insist that if RHNS beds are required to be converted to the higher level Chronic and Convalescent Nursing Home (CCNH) licensure, that the Medicaid rates for those beds be increased to meet the additional staffing requirements and costs of the CCNH level. For a nursing home that currently has both levels of care, any rate adjustment must not be achieved through the "blending" of the RHNS and CCNH bed rates - which has been the state's previously proposed approach. Those homes that have sought to convert the beds in the last several years have been told that they must combine their RHNS and CCNH rates to create a blended rate for all of the beds and which would mean lowering their CCNH rate in order raise the RHNS rate. As a result, they have not converted the beds because it was not financially feasible. **Therefore, we ask that this bill specifically address this issue and require an increase in the RHNS rate without lowering the CCNH rate.**

This section of the bill also includes a definition of "nursing home" on lines 153 – 160 that we do not agree with and which seems to have been newly created. The reference should simply be: *A nursing home, as defined in section 19a-490 of the general statutes.*

Finally, this section (lines 175 – 176) would mandate nursing homes always offer a 12-hour shift option to all staff. While the option of utilizing a 12- hour shift during a workforce crisis brought on by the virus was discussed, we do not believe it was the intent of the working group to mandate that all nursing homes always offer this option to all of their work force. **Many nursing homes would find this mandate to be unworkable and we cannot support it**.

Section 14.

We support the establishment of a comprehensive statutory framework to govern and facilitate the use of technology by residents in nursing homes. It is important to establish good public policy on this important issue - and we need to do it right.

Allowing resident access to and use of technology for the purpose of visitation and socialization was an issue raised and discussed in the NHALOWG subcommittees. After years of debate here in the General Assembly, we knew there would be an interest in not only permitting access, but also enabling surveillance. As a result, we updated our comprehensive analysis of all the state statutes that had been passed over the last several years in this regard and drafted what we

considered to be a comprehensive approach to the entire issue of communication technology in a nursing home setting

We have been involved in discussions with the Aging Committee on this issue as they raised a related bill earlier in the session. We provided extensive written comments on their initial proposal with the intent of assisting in the development of a statute that addresses the many complex needs and concerns of ensuring resident rights within this highly regulated setting and in consideration of the common situations that impact many nursing home residents. Many of our comments were accepted and we plan to continue to work with the Committee to help shape the legislation. We have included this link to our comments in this testimony.

Our priority goal is to ensure the self-determination, privacy and dignity of the nursing home resident. The proposal in the bill before you would apply only to "nonverbal" residents, but we would prefer and strongly suggest a more comprehensive statute that is inclusive of all situations. We would be eager to work with this Committee as well as others to ensure that any statute that enacted creates good public policy for all those residing within the nursing home.

Thank you for this opportunity to testify on this bill. We know we have made extensive comments on several sections of the bill and we would be happy to provide suggested substitute language if that would be helpful to the Committee.

Respectfully submitted,

Mag Morelli, President of LeadingAge Connecticut
mmorelli@leadingagect.org, (203) 678-4477, 110 Barnes Road, Wallingford, CT 06492
www.leadingagect.org

EXHIBIT F

CT Comm. Tran., PH 3/17/2021


Image 1 within document in PDF format.

Connecticut Public Health Committee Transcript, March 17, 2021

March 17, 2021
Public Health
2021

March 17, 2021

df/si PUBLIC HEALTH COMMITTEE 9:00 A.M.

CHAIRPERSONS:	Senator Mary Daugherty Abrams, Representative Jonathan Steinberg
SENATORS:	Anwar, Kushner, Haskell, Hwang, Kasser, Moore, Somers
REPRESENTATIVES:	Arnone, Berger-Girvalo, Betts, Carpino, Cook, Dauphinais, Demicco, Foster, Genga, Green, Gilchrest, Kavros DeGraw, Kennedy, Klarides-Ditria, Linehan, McCarty, Parker, Petit, Ryan, Tercyak, Young, Zupkus

REP. STEINBERG (136TH): Good morning.This is the Public Health Committee, in case you tuned into the wrong station this morning.I am State Representative Jonathan Steinberg, Co-Chair of the Public Health Committee, and I'm here today with my wonderful Co-Chair Senator Mary Daugherty Abrams, who hails from Ireland, at least going back some generations, as I imagine many of us on the call are today.

We have a number of Bills for today's Public Hearing.We have a good number of speakers, and let us get to the business at hand.I will turn it over to my Co-Chair for any opening comments.

SENATOR DAUGHERTY ABRAMS (13TH): I am Senator Mary Daugherty Abrams, and the Co-Chair of Public Health, and I'm excited today to hear the feedback on these Bills and to make them the best that they can possibly be.Thank you very much, and hope we have a great day.Jonathan, you're muted.

REP. STEINBERG (136TH): I don't remember muting myself.Happy St. Patrick's Day.Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chairman.A busy day in front of us with five Bills and almost 130 people signed up, so I hope we will get to the point and ask incisive questions and do the best we can to determine whether any or all of these Bills need to proceed forward.Happy St. Patrick's Day to everybody.We will probably see you tonight around 10:00 P.M.

SENATOR STEINGBERG (136TH): Well I hope you're wrong about that, Representative.Senator Hwang.

SENATOR HWANG (28TH): Thank you, Mr. Chair and Happy St. Patrick's Day to all.I am eager to hear the testimony as well, particularly a number of the Bills, but particularly on theSenate Bill 1, on the mental health, behavioral and physical health during this pandemic.And it is critical and I want to be able to offer that this is a concept that has true bipartisan support.And through the Public Hearing process and input from various shareholders that we can indeed craft a Bill meeting that goal.

So I'm eager to learn more, but I also wanted to share that there are many other Committee hearings going on via Zoom, that there may be many of our colleagues that are going in and out.Knowing that this is of very strong interest, I know they're going to be very engaged but I wanted to acknowledge that.

REP. COOK (66TH): And so what would be the difference between what was currently a Statute and what would we are proposing moving forward?Because my understanding was every facility was already supposed to have an infectious disease specialist and they were not.So why would we think, and I'm all about it, so but shy would we think that this legislation is going to change that?How are we going to look at accountability?

CHIEF ADELITA OREFICE: So the infection preventionist requirement currently is required by CMS, the Centers for Medicare and Medicaid Services, and I might ask Carbara Cass, who I think is on as well, to talk in more detail about that.But that requirement didn't compel facilities to have a fulltime infection preventionist and nor did it require the infection preventionist to sort of be, you know sort of exclusive to this, to the rule.

And so what we found through the pandemic is people in multiple hats playing that role.And clearly during the pandemic that, that part-time aspect of it didn't, didn't appear for a lot of facilities to be enough.

I know that the Bill in front of you also includes training for other senior leadership in the facilities on like the administrator on infection prevention and protocols.And that is in part to, you know have that larger foundation or stronger foundation with infection prevention throughout the leadership and management on team of a facility because even if you have, you know the full-time infection preventionist in your, your team of shift coaches, what we saw also during the pandemic is sometimes the infection preventionist was the one who got sick.

And then you needed to have a backup.You needed to have enough of a safety net of competency in the facility to cover that.

REP. COOK (65TH): Thank you for that.I think it's extremely important, obviously, from what we've learned and then you know the shortcomings of our facilities in this area, so I want to thank you for that and I do want to ensure that we figure out a way to, to look at some type of oversight in that area.Even though we are supposed to have part-time folks, we know that they didn't and so it's extremely important that we start holding these facilities accountable for their shortcomings because they are putting lives in, you know we're costing lives quite frankly.

The other thing I would like to address would be the staffing levels.I'm sure that you figured that where I would be I would be going to when we're looking at the staffing levels, I want to thank you all for your support in that regard and I know that we had suggested a variety of different opportunities for shift options and so forth and so on.

Is the Department, and I heard your testimony but I didn't hear your say one way or another, are you in complete support of what we're, where we are or are you looking at alterations from the recommendations that we have for staffing level ratios, etcetera?

COMMISSIONER GIFFORD: Representative, I think the Department would like to continue to have the conversation of minimum staffing ratios.We certainly understand the impetus behind it and ensuring that there is always adequate staff to meet the needs of the residents based on their acuity.

Well I think we would also want to talk about the implications of the minimum staffing ratios or financial support of the facility, so I think we probably are aligned on the intent and want to just engage you a little bit more on the specifics and how it would be implemented and supported.

REP. COOK (66TH): And I'm happy to continue this conversation.It's a conversation that I have been having with the Departments for many, many year's pre, you know pre-pandemic and I'm sure it will go on post-pandemic.

My, my fear is that if we do not figure out a way to invest in and hold our facilities accountable, especially the for profit facilities when their owners and operators are taking a very nice salary and we are short changing our residents.That for me is, is criminal.

We have seen a significant amount of lives lost because of the pandemic but I don't believe that all the lives that were lost during the pandemic are lives that should have been lost for a variety of reasons, and I don't think there's anybody here that would argue that point.

EXHIBIT G

OFFICE OF FISCAL ANALYSIS
Legislative Office Building, Room 5200
Hartford, CT 06106 ◇ (860) 240-0200
http://www.cga.ct.gov/ofa

sSB-1030
AN ACT CONCERNING LONG-TERM CARE FACILITIES.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 22 $	FY 23 $
Public Health, Dept.	GF - Cost	5.4 million	2.4 million
State Comptroller - Fringe Benefits[1]	GF - Cost	82,130	84,600
Social Services, Dept.	GF - Cost	See Below	See Below

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill results in cost to the Department of Public Health (DPH) and the Department of Social Services (DSS) associated with requirements for long-term care facilities to build infection control capacity and new minimum staffing levels for nursing homes.

Section 1 results in a cost of approximately $96,340 in FY 22 and $96,170 to DPH (with associated fringe of $38,160 in FY 22 and $39,310 in FY 23) for infection control training. The Healthcare-Associated Infections & Antimicrobial Resistance (HAI-AR) Program provides technical assistance to healthcare facilities in infection control and prevention. HAI-AR will need an additional Nurse Consultant to support technical assistance with infection control to allow long-term care facilities to comply with the bill.

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 41.3% of payroll in FY 22 and FY 23.

Primary Analyst: ES 4/13/21
Contributing Analyst(s): RDP, LD, CP

Section 3 results in a cost associated with requiring DPH to maintain a 90-day stockpile of personal protective equipment (PPE) that will be used to supply long-term care facilities during a public health emergency. Funding of approximately $106,460 in FY 22 and $109,660 in FY 23 (with associated fringe of $43,970 in FY 22 and $45,290 in FY 23) will support two Material Storage staff to help manage PPE. DPH will also incur costs of approximately $3.2 million in FY 22 and $200,000 in FY 23 associated with PPE supplies, storage, and an inventory management system. In addition, the bill results in a cost of approximately $2 million in FY 22 and FY 23 to support a maintenance contract with a vendor to resupply the needed PPE prior to expiration.

Section 13 results in a cost to DSS associated with revising nursing home staffing levels and eliminating the distinction between a chronic and convalescent nursing home and a rest home with nursing supervision.

Staffing ratio requirements will result in a significant cost to DSS to the extent nursing home staffing costs are reflected in future Medicaid payments. The bill specifies that a total of 4.1 hours of direct care be provided per resident per day, including 3.75 hours by a registered nurse (RN), 0.54 hours by a licensed practical nurse (LPN), and 2.81 hours by a certified nurse's assistant (CAN).

Based on 2019 nursing home staffing data, none of the approximately 200 homes can meet the bill's requirements for RNs (with an average of 0.70 hours of direct care provided per resident per day). Approximately 10% of homes do not meet the LPN staffing requirements, while approximately 80% do not meet the requirements for CNAs. The cost for nursing homes to staff at the proposed levels will depend on the actual number and level of staff required and their associated wages but is anticipated to be at least $200 million.

The Out Years

The annualized ongoing fiscal impact identified above would

continue into the future subject to inflation.

EXHIBIT H

General Assembly

Amendment

January Session, 2021

LCO No. **9433**

Offered by:
SEN. DAUGHERTY ABRAMS, 13th Dist.
REP. STEINBERG, 136th Dist.

To: Subst. Senate Bill No. **1030** File No. 457 Cal. No. 281

"AN ACT CONCERNING LONG-TERM CARE FACILITIES."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. (NEW) (*Effective October 1, 2021*) (a) As used in this section and sections 2 to 11, inclusive, of this act:

(1) "Nursing home" means any chronic and convalescent nursing home or any rest home with nursing supervision that provides nursing supervision under a medical director twenty-four hours per day, or any chronic and convalescent nursing home that provides skilled nursing care under medical supervision and direction to carry out nonsurgical treatment and dietary procedures for chronic diseases, convalescent stages, acute diseases or injuries; and

(2) "Dementia special care unit" means the unit of any assisted living

facility that locks, secures, segregates or provides a special program or unit for residents with a diagnosis of probable Alzheimer's disease, dementia or other similar disorder, in order to prevent or limit access by a resident outside the designated or separated area, or that advertises or markets the facility as providing specialized care or services for persons suffering from Alzheimer's disease or dementia.

(b) Each nursing home and dementia special care unit shall employ a full-time infection prevention and control specialist who shall be responsible for the following:

(1) Ongoing training of all administrators and employees of the nursing home or dementia special care unit on infection prevention and control using multiple training methods, including, but not limited to, in-person training and the provision of written materials in English and Spanish;

(2) The inclusion of information regarding infection prevention and control in the documentation that the nursing home or dementia special care unit provides to residents regarding their rights while in the home or unit and posting of such information in areas visible to residents;

(3) Participation as a member of the infection prevention and control committee of the nursing home or dementia special care unit and reporting to such committee at its regular meetings regarding the training he or she has provided pursuant to subdivision (1) of this subsection;

(4) The provision of training on infection prevention and control methods to supplemental or replacement staff of the nursing home or dementia special care unit in the event an infectious disease outbreak or other situation reduces the staffing levels of the home or unit; and

(5) Any other duties or responsibilities deemed appropriate for the infection prevention and control specialist, as determined by the nursing home or dementia special care unit.

(c) Each nursing home and dementia special care unit shall require its infection and control specialist to work on a rotating schedule that ensures the specialist covers each eight-hour shift at least once per month for purposes of ensuring compliance with relevant infection control standards.

Sec. 2. (NEW) (*Effective October 1, 2021*) On or before January 1, 2022, the administrative head of each nursing home and each dementia special care unit shall provide its emergency plan of operations to the political subdivision of this state in which it is located for purposes of the development of the emergency plan of operations for such political subdivision of this state required pursuant to the Interstate Mutual Aid Compact made and entered into under section 28-22a of the general statutes.

Sec. 3. (NEW) (*Effective October 1, 2021*) (a) The administrative head of each nursing home shall ensure that (1) the home maintains at least a two-month supply of personal protective equipment for its staff, and (2) the personal protective equipment is of various sizes based on the needs of the home's staff. The personal protective equipment shall not be shared amongst the home's staff and may only be reused in accordance with the strategies to optimize personal protective equipment supplies in health care settings published by the National Centers for Disease Control and Prevention. The administrative head of each nursing home shall hold fittings of his or her staff for N95 masks or higher rated masks certified by the National Institute for Occupational Safety and Health, at a frequency determined by the Department of Public Health.

(b) On or before January 1, 2022, the Department of Emergency Management and Homeland Security, in consultation with the Department of Public Health, shall establish a process to evaluate, provide feedback on, approve and distribute personal protective equipment for use by nursing homes in a public health emergency.

Sec. 4. (NEW) (*Effective October 1, 2021*) The administrative head of each nursing home shall ensure that there is at least one staff member

or contracted professional licensed or certified to start an intravenous line who is available on-call during each shift to start an intravenous line.

Sec. 5. (NEW) (*Effective October 1, 2021*) Each nursing home's infection prevention and control committee shall meet (1) at least monthly, and (2) during an outbreak of an infectious disease, daily, provided daily meetings do not cause a disruption to the operations of the nursing home, in which case the committee shall meet at least weekly. The prevention and control committee shall be responsible for establishing infection prevention and control protocols for the nursing home and monitoring the nursing home's infection prevention and control specialist. Not less than annually and after every outbreak of an infectious disease in the nursing home, the prevention and control committee shall evaluate (A) the implementation and analyze the outcome of such protocols, and (B) whether the infection prevention and control specialist is satisfactorily performing his or her responsibilities under subsection (b) of section 1 of this act.

Sec. 6. (NEW) (*Effective October 1, 2021*) Each nursing home shall, during an outbreak of an infectious disease, test staff and residents of the nursing home for the infectious disease at a frequency determined by the Department of Public Health as appropriate based on the circumstances surrounding the outbreak and the impact of testing on controlling the outbreak.

Sec. 7. (NEW) (*Effective October 1, 2021*) On or before January 1, 2022, the administrative head of each nursing home and dementia special care unit shall encourage the establishment of a family council and assist in any such establishment. The family council shall facilitate and support open communication between the nursing home or dementia special care unit and each resident's family members and friends. As used in this section, "family council" means an independent, self-determining group of the family members and friends of the residents of a nursing home or dementia special care unit that is geared to meeting the needs and interests of the residents and their family members and friends.

Sec. 8. (NEW) (*Effective October 1, 2021*) (a) On or before January 1, 2022, the administrative head of each nursing home shall ensure that each resident's care plan includes the following:

(1) Measures to address the resident's social, emotional and mental health needs, including, but not limited to, opportunities for social connection and strategies to minimize isolation;

(2) Visitation protocols and any other information relevant to visitation that shall be written in plain language and in a form that may be reasonably understood by the resident and the resident's family members and friends; and

(3) Information on the role of the Office of the Long-Term Care Ombudsman established under section 17a-405 of the general statutes including, but not limited to, the contact information for said office.

(b) On or before January 1, 2022, the administrative head of each nursing home shall ensure that its staff is educated regarding (1) best practices for addressing the social, emotional and mental health needs of residents, and (2) all components of person-centered care.

Sec. 9. (*Effective from passage*) On or before October 1, 2021, the Public Health Preparedness Advisory Committee established pursuant to section 19a-131g of the general statutes shall amend the plan for emergency responses to a public health emergency prepared pursuant to said section to include a plan for emergency responses to a public health emergency in relation to nursing homes and dementia special care units and providers of community-based services to residents of such homes and units.

Sec. 10. (NEW) (*Effective October 1, 2021*) (a) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for nursing homes of three hours of direct care per resident per day, and (2) modify staffing level requirements for social work and recreational staff of nursing homes such that the requirements (A) for social work are one full-time social worker per

sixty residents, and (B) for recreational staff are lower than the current requirements, as deemed appropriate by the Commissioner of Public Health.

(b) The commissioner shall adopt regulations in accordance with the provisions of chapter 54 of the general statutes that set forth nursing home staffing level requirements to implement the provisions of this section.

Sec. 11. (*Effective from passage*) The Department of Public Health shall seek any federal or state funds available for improvements to the infrastructure of nursing homes in the state. Not later than January 1, 2022, the Commissioner of Public Health shall report, in accordance with the provisions of section 11-4a of the general statutes, regarding the commissioner's success in accessing such federal or state funds available for infrastructure improvement to the joint standing committee of the General Assembly having cognizance of matters relating to public health."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2021*	New section
Sec. 2	*October 1, 2021*	New section
Sec. 3	*October 1, 2021*	New section
Sec. 4	*October 1, 2021*	New section
Sec. 5	*October 1, 2021*	New section
Sec. 6	*October 1, 2021*	New section
Sec. 7	*October 1, 2021*	New section
Sec. 8	*October 1, 2021*	New section
Sec. 9	*from passage*	New section
Sec. 10	*October 1, 2021*	New section
Sec. 11	*from passage*	New section

EXHIBIT I

OFFICE OF FISCAL ANALYSIS
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sSB-1030
AN ACT CONCERNING LONG-TERM CARE FACILITIES.
AMENDMENT

LCO No.: 9433
File Copy No.: 457
Senate Calendar No.: 281

OFA Fiscal Note

See Fiscal Note Details

The amendment strikes the language in the underlying bill and the associated fiscal impact.

The amendment results in a cost to the Department of Social Services associated with eliminating the distinction between a chronic and convalescent nursing home and a rest home with nursing supervision and increasing minimum staffing level requirements in nursing homes.

The amendment requires the Department of Public Health (DPH) to establish a minimum staffing level of three hours of direct care per resident per day, by January 1, 2022. Based on 2019 cost report data, there are several homes providing less than three hours of direct care per resident per day. The total cost for these homes to meet the amendment's provisions is approximately $600,000 to $1 million. If the state supported those costs through increased rates, it would result in a state Medicaid cost of $300,000 to $500,000. The actual cost depends on the number and type of staff required.

The amendment also requires DPH to modify staffing requirements to (1) include one full-time social worker per sixty residents, and (2) reduce current staffing requirements for recreational staff. The net impact will depend on the adjusted staffing required for each home and the extent to which associated costs are reflected in Medicaid rates.

Primary Analyst: ES 5/27/21
Contributing Analyst(s): (FN)

The preceding Fiscal Impact statement is prepared for the benefit of the members of the General Assembly, solely for the purposes of information, summarization and explanation and does not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

Sources: 2019 Annual Cost Reports of Long Term Care Facilities per the Department of Social Services

EXHIBIT J

CT S. Tran., 5/27/2021

Image 1 within document in PDF format.

Connecticut Senate Transcript, May 27, 2021

May 27, 2021
Connecticut Senate
2021

CONNECTICUT GENERAL ASSEMBLY

SENATE

Thursday, May 27, 2021

The Senate was called to order at 2:38 p.m., the President in the Chair.

THE CHAIR:

The Senate will please come to order.Give your attention to our guest Chaplain Kathy Zabel of Burlington.

ACTING CHAPLAIN KATHY ZABEL OF BURLINGTON:

Help us to live a creative life, to lose our fear of being wrong, and to let us find common ground with others.Let us know that in all things, we are not alone but are surrounded by the wisdom and kindness of our fellow man.

THE CHAIR:

Thank you very much, Madam Chaplain.We now invite Senator Winfield and Senator Berthel to come forward to lead us in the Pledge of Allegiance.

SENATOR WINFIELD (10TH) & SENATOR BERTHEL (32ND):

I pledge allegiance to the flag of the United States of America and to the republic for which it stands, one nation, under God, indivisible, with liberty and justice for all.

THE CHAIR:

Thank you very much to both Senators.Is there business on the Clerk's desk?

CLERK:

Good afternoon.The Clerk is in possession of Senate Agenda Item No. 1, dated Thursday, May 27th, 2021.

THE CHAIR:

Thank you, Mr. Clerk.Our distinguished Majority Leader, Senator Duff.

SENATOR DUFF (25TH):

Thank you, Mr. President.Good to see you this afternoon.Mr. President, I move all items on Senate agenda No. 1, dated Thursday, May 27th, 2021, be act upon as indicated and that the Agenda be incorporated by reference into Senate Journal and Senate Transcripts.

Good evening Senator.

SENATOR DAUGHERTY ABRAMS (13TH):

Good evening, Madam President.I move acceptance of the Joint Committee's favorable report and passage of the Bill.

THE CHAIR:

And the question is on passage, will you remark?

SENATOR DAUGHERTY ABRAMS (13TH):

Thank you, Madam President, the Clerk is in possession of LCO No. 9433.I ask that the Clerk please call it.I move the Amendment and ask leave to summarize.

THE CHAIR:

Mr. Clerk.

CLERK:

LCO No. 9433 Senate Schedule “A”

THE CHAIR:

And please do proceed to summarize and the question is on adoption of the Amendment.

SENATOR DAUGHERTY ABRAMS (13TH):

Thank you very much, Madam President.I cannot begin to talk about this Bill or this Amendment without remembering first the thousands of people, grandparents, mothers, fathers, sisters, brothers, residents of nursing home in assisted care living facilities who lost their lives due to COVID.Also, the staff members who put themselves and their family members at risk to take care of our most vulnerable citizens.These are the sacrifices that we must never forget.

For me, this legislation is an acknowledgment of that sacrifice.It is the most sincere hope that this Bill honors them by acting on our commitment to do better.This amended Bill is a culmination of the work of stakeholders, the Department of Public Health, the Chairs and Ranking Members of Public Health, Human Services and Appropriations Committees who held workgroups through the fall and into the winter to consider the recommendations of the Mathematica report and to evaluate current practices in nursing homes and assisted living facilities.

The Bill, as amended from the -- was amended from the original Bill because some parts of the original Bill have been taken up in other Committees.In Human Services and in the Aging Committee.In addition, changes have been made to address the fiscal note and feedback from various stakeholders.

This Bill, as amended, codifies the role of the infection preventionist.It's previously been in statute but not clearly defined.This legislation would ask that that person be full-time.They can be assigned to other duties, however.And would be asked to have a rotating schedule monthly so that they can see what is happening in the facility during all times of the day.They'd be responsible for training all administrators and staff on infection prevention and control using multiple training methods, including in-person training.They be responsible for written materials and resident documents and -- written materials that would be posted in the building that would show best practices in infection prevention.They would participate as a member of the Infection Prevention Control Committee to report on their activities.

The Infection Prevention and Control Committee would also ask to meet monthly, daily during an outbreak.They would be responsible for establishing infection prevention and control protocols, evaluate those protocols at least annually, and always after an outbreak.

We also address in this Bill PPE.Nursing homes would be asked to have a two month supply in various sizes that reflect the needs of their staff.There would be no sharing or reuse, only to -- only if it would be recommended by the CDC. It also asks that every nursing home have at least one staff member or contract professional to start an IV line available during every shift.It addresses the testing of staff and residents.It ask that nursing homes and assisted living facilities help to create family councils.It ask that the resident care plan address the social emotional needs of residents, training for staff on all components of the person centered care plan, and the social-emotional needs of the residents as well.

Staffing would be increased.Currently it's 1.9 hours per resident per day.This would increase that to 3.0.It would also increase the ratio of social workers from one to 120, to one to 60, and increase -- and increase recreational staff as determined by the public health department.

Social workers are responsible for the intake and discharge of patients for working with families and for really creating those residential care plans that address the social emotional needs of residents.We also ask in this legislation that DPH be charged to seek state and federal funds to support improvements to the infrastructure of our nursing homes.

When this pandemic began I was on weekly, sometimes daily calls regarding long-term care facilities and how we could mitigate the impact of COVID on those residents.I remember hearing that these facilities knew how to respond to infectious outbreaks.The pandemic certainly tested their ability to do that, and what we found is that we must do better.

In passing this Bill we will be doing better, so I encourage all members of the Chamber to support this Bill.Thank you.

THE CHAIR:

Thank you very much.Will you remark further?Will you remark further?Senator Somers.

SENATOR SOMERS (18TH):

Yes, good evening, Madam President.And I rise in full support of this Bill.In fact, I think it's one of the most important pieces of legislation that we will pass in this session.I should say I hope we pass this session.

One thing that the COVID pandemic has clearly shown us here in the State of Connecticut is the voids in the system that we have for caring for our elderly and long-term care in assisted living facilities.There is not one of us, I believe, in this circle that was not contacted by a family member of a loved one who was in a long-term care facility, or an assisted living facility during the COVID pandemic and during the unfortunately large loss of life that we saw here in the State of Connecticut.

I have to say that the people that work in these facilities really do God's work.It is not an easy job, and they do it with care and love and a true dedication for those who are a little more advanced in age than most of us here in the circle.

One of the things that is very clear is that this industry has -- needs some attention from our state.I think they did the best job they could under the circumstances.We all know that PPE was short in supply.We didn't realize how the virus could be transmitted at first, and unfortunately, we even had at times the National Guard going into our facility to help, but without actually being tested for COVID themselves because at that time we didn't understand the transmission.

I too received calls, sometimes on an hourly basis from some of our facilities asking for help, from family members of loved ones that felt that they were locked inside and couldn't have contact with the outside world, but most of our facilities did a great job in trying in the best of their ability to keep that contact going, whether it was through tablets that they could have, waving out the window.I know I myself, I personally visited many of these facilities obviously on the outside waiving to the individuals inside where just seeing somebody new could really brighten their day.

We saw a lot of mental health issues coming out of being isolated during the pandemic where the elderly in particular, especially those that have dementia or Alzheimer's were severely affected by this pandemic because they were moved out of their original routines.And not being able to see or have the contact with the person they were used to took its toll on so many individuals.I do believe that this industry and the long-term care that we'll see in the State of Connecticut is going through a significant change and we will see long-term care being delivered in a different way than we're seeing it now in the future.

But what this Bill does is it starts the beginning of the process, I believe, a process to improve the long-term care that we can provide to our citizens in the State of Connecticut.It looks at infection prevention, infection control, it looks at staffing levels that are reasonable and are affordable.It looks at emergency plan.It deals with visitation of loved ones.It deals with patients' rights.It deals -- also talks about testing and the necessity to make sure that our patients social and emotional needs are met the best they can.

I want to thank all of those who were engaged, including Madam President in this process of reviewing the Mathematica report of breaking out into individual workgroups, of working with the stakeholders and those who are actually working in this -- in these facilities because those truly are the people that can give us the best information so that we can adequately and strategically implement policies that can benefit the residents that live in these facilities here in the State of Connecticut.

So I ask that my colleagues in the Senate join myself and the Chair of public health, Senator Abrams, and support this very important and critical legislation that I do believe is one of the most important Bills that we could look at passing in this session.Thank you, Madam President.

THE CHAIR:

Thank you very much, Senator Somers.Will you remark further?Will you remark further?Senator Hwang.

SENATOR HWANG (28TH):

Thank you, Madam President.I rise in support of the strike-all Amendment.And I want to commend the Chair in the Senate along with the Chair of the House, Representative Steinberg, as well as the House Ranking Member Dr. Petit, and has mentioned before, I want to echo those terms because the uniqueness of the COVID challenge that we went through has raised significant awareness and sensitivity.And I hope this is a valuable lesson that we garnered from this in looking at this Bill and addressing staffing levels and reporting.It is an important and critical element that I hope we will continue as we head into the new normal, post-COVID dynamic that we're experiencing.

But that being said, I also want to commend the fact that our nursing facilities came to the table and collaborated and worked and understood the need to up their game so to speak in meeting the requirements of proper care, proper ratios, and proper reporting.So I think this is a Bill that is a great template for moving forward, as we look at public-private dynamics and us as a state looking to ensure the highest and best care for our loved ones that are at these facilities but also ensuring that we are working with our business partners to provide the highest and best care and sustainability and being in this state and doing business.

So I thank the good Chair for her efforts and collaboration and I urge supporter as well, ma'am.

THE CHAIR:

Thank you very much.Will you remark further?Will you remark further?Senator Looney.

SENATOR LOONEY (11TH):

Thank you, Madam President.Speaking in support of the Bill, rather the Amendment, want to commend the Public Health Committee for all of its works, Senator Daugherty Abrams on this Bill as so many others.

EXHIBIT K

CHAIRPERSONS: Senator Catherine Osten,
Representative Toni Walker

SENATORS: Marx

REPRESENTATIVES: Candelaria, Dathan, Delany, Dillon, Exum, Foncello, Gilchrest, Kennedy, Khanna, McCarty, Nolan, Nuccio, Paris, Ryan

REP. WALKER (93RD): Good morning, everybody. Good morning. I'd like to welcome everybody to the Appropriation's Health Agency presentation, and I think we've canceled this either one or two times. Either it's been weather or was the IT system, or it's -- so we got here, and I'm really happy. I want just to let everybody know the lineup today for the hearings before I start.

From 10 to 11, we have the Department of Public Health. From 11 to 12, we have the Department of Developmental Services. From 1:00 to 1:30, we have the Department of Veteran Affairs. From 1:30 to 2:00, we have the Office of Chief Medical Examiner. From 2:00 to 2:30, we have the Office of -- the new office of -- Office of Health Strategy. And from 2:30 to 3:30, Department of Mental Health and Addiction Services.

The public hearing for the health agencies will be held on March 9th. I believe we start at 10 o'clock, but I'm not exactly sure, but I will try and find that out and let everybody know who's watching us today. So, with that --

ADMINISTRATOR SUSAN KEANE: Madam Chair?

REP. WALKER (93RD): Yes, ma'am.

ADMINISTRATOR SUSAN KEANE: That is correct.

So that's what that review committee will ultimately do when they select who the eventual applicant's selectees are.

SENATOR OSTEN (19TH): I appreciate that. I also know that a lot of times people can write a very good report and still have no results that would come out as a result of that. And that concerns me that we would try to go in a new direction when we have proven success in groups like this. So that was -- If you could bring that process that they will go through to the subcommittee workshop, that would be great.

And relative to contracts that you have to do for new water systems, most recently in one of the last bond commission meetings before -- I think it was before the first of the year, it might have been right in January, there's a group in Lebanon that has an at-risk water system. Have you reached out -- has your agency reached out to them to develop that contract with them yet?

CMMR. MANISHA JUTHANI: Lori, do you have any additional information on that? I'm not familiar specifically with that contract. We can get back to you with more information. Do you have anything further?

LISA MORRISSEY: My understanding is our engineers have been in contact, if you're talking about that one small system in Lebanon.

SENATOR OSTEN (19TH): The Carefree. Carefree, yes.

LISA MORRISSEY: We believe our engineers, but we can get more sufficient [inaudible 1:03:02]

SENATOR OSTEN (19TH): Okay, great. My last question is -- [crosstalk] I'm sorry, you know, my mind works in bad ways, really bad ways. I'm trying to figure out what we're doing. We looked at coming up with a staffing ratio for nursing homes, and you set the staffing ratios. And my understanding is

the staffing ratio that is being set by the rules and regulations from DPH is different than the staffing ratio that we called for in the budget. Because we put a financial number on that staffing ratio. And this is going to cause an increased cost to nursing homes. And so to the working group, if you wouldn't mind bringing back your analysis and what you came up with as a result of a fiscal note. Because by my analysis we would have to at least increase the fiscal note by half.

And so I just want to make sure that if that's going to be the case, that you're also supporting us putting the dollars in for the nursing homes to comply with the staffing ratio you're setting up. And it does not appear to be so right now, you may have a different analysis, and I appreciate looking at that, but that is not what I see right now. So if you wouldn't mind bringing that to the working group, I'd appreciate it. Thank you very much, Madam Chair.

CMMR. MANISHA JUTHANI: If I can just make one comment on that. The fiscal note really would be DSS, because we don't do that piece of it. What we're operationalizing is the 3.0 request that the legislature put forward.

SENATOR OSTEN (19TH): And we did a combination, and you're separating it out doing LPNs under the CNA numbers. Your numbers are much higher than the numbers that we have. And while I appreciate that you don't pay the nursing homes. If you set a rule or regulation that increase the cost of the nursing home, that has to be part of our consideration in accepting those rules changes and that's what I'm concerned about. Because the only money they get, group homes, nursing homes, the only money they get by and large is from the State through Medicaid. Very few private payers in any of this.

And if we're going to increase their costs, even though that is not your responsibility, I think there needs to be a collaboration because your

analysis increases their cost. If you increase their cost, then we need to know about that. And if you are not talking with DSS, we're not going to know that. We happen to know it because as soon as you did that, the increased costs came to our attention.

CMMR. MANISHA JUTHANI: We've been in direct conversations with everybody in the industry. And DSS I just want to highlight that our goal and our understanding from the law, the way it was written, was to increase facing time with patients. And that goal was to provide care to patients. And just to highlight, even increasing to 3.0, it is the lowest out of our surrounding states.

SENATOR OSTEN (19TH): I'm not saying we shouldn't do this. I'm not saying that.

CMMR. MANISHA JUTHANI: Our focus is quality of care. That's all.

SENATOR OSTEN (19TH): I understand that that's your focus. I'd like to do everything as quality of care for everything that comes before me. Everything that comes before me has a fiscal note, and I have to say no to people that want to do things. I have to say no to educators. I have to say no to firefighters. I have to say no to ambulance services. I have to say no to group homes. You can't have a rule that increases their cost without us knowing about it, because that puts them in a very difficult position. And it puts us in a difficult position because we have to incorporate that cost into our budget and that's my concern.

And I don't want any agency coming to me and saying that they're concerned about quality of care when I'm also concerned about quality of care, I have to pay for it. All of us here are paying for it. And so to say that -- I find that to not understand the process and that worries me. So if you wouldn't mind bringing your analysis to the group, that would be great. Thank you. Thank you, Madam Chair.

EXHIBIT L

Direct Care Minimum Staffing Increases

Public Act 21-185, established a nursing home minimum staffing level of three hours of direct care per resident per day. Public Act 21-2, June special session allocated up to $500,000 in State funding to the Department of Social Services, for Medicaid for each of the fiscal years ending June 30, 2022 and June 30, 2023, to support the minimum nursing home staffing requirement. Nursing homes that are not currently providing such staffing may complete an application to be considered for a Medicaid rate increase to support a staffing increase up to the minimum.

Available Funding $ 1,000,000

Requirement-3.1 Direct Care Hours Per Resident per Day

Direct Care Add-on Calculation

Facility	Management Company		Cost Year 2022 Total Resident Days	Cost Year 2022 Medicaid Days	A Cost Year 2022 Actual and Imputed Days	B Bed Capacity	C Additional Fees per Application	D Additional Salaries per Application	Benefits per Application	E Allowable FICA Increase		F = C + D + E Total Increase In Expense	H Prorated Share of Funding	G = H/A Per Diem Add-on	Estimated Additional Medicaid Payments	Implementation Date	Comment
Apple Rehab Avon	Apple Health Care Inc.		12,269	8,674	19,710	60	$ -	$ 45,760.00	$ 16,016.00	$ -	^	$ 61,776.00	$ 2,719.44	$ 0.14	$ 1,196.78	6/1/2023	
Apple Rehab Farmington Valley	Apple Health Care Inc.		36,315	24,039	52,560	160	$ -	$ 45,760.00	$ 16,016.00	$ -	^	$ 61,776.00	$ 2,719.44	$ 0.05	$ 1,243.77	6/1/2023	
Apple Rehab Guilford	Apple Health Care Inc.		28,544	21,187	29,565	90	$ -	$ 91,520.00	$ 32,032.00	$ -	^	$ 123,552.00	$ 5,438.88	$ 0.18	$ 3,897.64	6/1/2023	
Apple Rehab Middletown	Apple Health Care Inc.		18,219	13,479	22,995	70	$ -	$ 22,880.00	$ 8,008.00	$ -	^	$ 30,888.00	$ 1,359.72	$ 0.06	$ 797.03	6/1/2023	
Apple Rehab Mystic	Apple Health Care Inc.		15,113	7,180	19,710	60	$ -	$ 143,520.00	$ 50,232.00	$ -	^	$ 193,752.00	$ 8,529.16	$ 0.43	$ 3,107.02	6/1/2023	
Apple Rehab of Rocky Hill	Apple Health Care Inc.		22,829	17,847	39,420	120	$ -	$ 23,920.00	$ 8,372.00	$ -	^	$ 32,292.00	$ 1,421.53	$ 0.04	$ 643.58	6/1/2023	
Apple Rehab Shelton Lakes	Apple Health Care Inc.		35,165	27,253	35,478	108	$ -	$ 43,680.00	$ 15,288.00	$ -	^	$ 58,968.00	$ 2,595.83	$ 0.07	$ 1,994.03	6/1/2023	
Apple Rehab Uncasville	Apple Health Care Inc.		30,390	24,292	42,705	130	$ -	$ 23,920.00	$ 8,372.00	$ -	^	$ 32,292.00	$ 1,421.53	$ 0.03	$ 808.61	6/1/2023	
Apple Rehab West Haven	Apple Health Care Inc.		26,211	19,218	29,237	89	$ -	$ 91,520.00	$ 32,032.00	$ -	^	$ 123,552.00	$ 5,438.88	$ 0.19	$ 3,575.08	6/1/2023	
Apple Rehabilitation Watertown	Apple Health Care Inc.		32,994	23,497	36,135	110	$ -	$ 45,760.00	$ 16,016.00	$ -	^	$ 61,776.00	$ 2,719.44	$ 0.08	$ 1,768.33	6/1/2023	
Chesterfields Health Care Center	Apple Health Care Inc.		13,821	10,141	19,710	60	$ -	$ 23,920.00	$ 8,372.00	$ -	^	$ 32,292.00	$ 1,421.53	$ 0.07	$ 731.39	6/1/2023	
Coccomo Memorial Health Center	Apple Health Care Inc.		31,705	24,947	32,850	100	$ -	$ 45,760.00	$ 16,016.00	$ -	^	$ 61,776.00	$ 2,719.44	$ 0.08	$ 2,065.20	6/1/2023	
Gardner Heights Health Care Center, Inc.	Apple Health Care Inc.		35,281	30,496	42,705	130	$ -	$ 21,840.00	$ 7,644.00	$ -	^	$ 29,484.00	$ 1,297.92	$ 0.03	$ 926.85	6/1/2023	
Hewitt Health & Rehabilitation Center, Inc.	Apple Health Care Inc.		33,033	26,083	39,420	120	$ -	$ 21,840.00	$ 7,644.00	$ -	^	$ 29,484.00	$ 1,297.92	$ 0.03	$ 858.79	6/1/2023	
Ledgecrest Health Care Center, Inc	Apple Health Care Inc.		16,233	13,861	19,710	60	$ -	$ 152,880.00	$ 53,508.00	$ -	^	$ 206,388.00	$ 9,085.41	$ 0.46	$ 6,389.29	6/1/2023	
Saybrook Health Care Center	Apple Health Care Inc.		20,218	15,594	39,420	120	$ -	$ 91,520.00	$ 32,032.00	$ -	^	$ 123,552.00	$ 5,438.88	$ 0.14	$ 2,151.55	6/1/2023	
Bride Brook Rehab and Nursing Center	Atlas Healthcare	***	36,493	19,330	42,705	130	$ -	$ 526,240.00	$ 184,184.00	$ -	^	$ 710,424.00	$ 31,273.59	$ 0.73	$ 14,155.68	6/1/2023	
Manchester Rehabilitation and Healthcare Center	Atlas Healthcare	****	43,507	21,917	43,507	126	$ -	$ 131,040.00	$ 45,864.00	$ -	^	$ 176,904.00	$ 7,787.49	$ 0.18	$ 3,922.95	6/1/2023	
Pendleton Rehab and Nursing Center	Atlas Healthcare	***	30,165	17,182	39,420	120	$ -	$ 382,720.00	$ 133,952.00	$ -	^	$ 516,672.00	$ 22,744.43	$ 0.58	$ 9,913.62	6/1/2023	
Vernon Rehabilitation and Healthcare Center	Atlas Healthcare	****	38,198	25,428	38,198	120	$ -	$ 174,720.00	$ 61,152.00	$ -	^	$ 235,872.00	$ 10,383.33	$ 0.27	$ 6,912.20	6/1/2023	
Autumn Lake Healthcare at Bucks Hill LLC	Autumn Lake Healthcare		30,452	19,854	30,452	90	$ -	$ 509,458.00		$ 38,973.54		$ 548,431.54	$ 24,142.51	$ 0.79	$ 15,740.36	6/1/2023	
Autumn Lake Healthcare at Cromwell LLC	Autumn Lake Healthcare		50,915	37,940	57,488	175	$ -	$ 998,400.00		$ 76,377.60		$ 1,074,777.60	$ 47,312.80	$ 0.82	$ 31,224.74	6/1/2023	
Autumn Lake Healthcare at New Britain LLC	Autumn Lake Healthcare		87,346	61,476	92,637	282	$ -	$ 1,886,310.00		$ 144,302.72		$ 2,030,612.72	$ 89,389.64	$ 0.96	$ 59,320.98	6/1/2023	
Autumn Lake Healthcare at Norwalk LLC	Autumn Lake Healthcare		43,549	23,949	49,275	150	$ -	$ 530,400.00		$ 40,575.60		$ 570,975.60	$ 25,134.93	$ 0.51	$ 12,216.26	6/1/2023	
Chelsea Place	iCare Health Network		73,163	71,200	76,869	234	$ -	$ 1,423,758.00		$ 108,917.49		$ 1,532,675.49	$ 67,469.94	$ 0.88	$ 62,494.11	6/1/2023	
Farmington Care Center	iCare Health Network		29,555	22,405	34,493	105	$ -	$ 222,194.00		$ 16,997.84		$ 239,191.84	$ 10,529.47	$ 0.31	$ 6,839.44	6/1/2023	
Fresh River Healthcare	iCare Health Network		42,317	39,321	45,990	140	$ -	$ 620,889.00		$ 47,498.01		$ 668,387.01	$ 29,423.08	$ 0.64	$ 25,156.44	6/1/2023	
Parkville Care Center	iCare Health Network		43,403	41,063	49,275	150	$ -	$ 436,934.00		$ 33,425.45		$ 470,359.45	$ 20,705.70	$ 0.42	$ 17,254.96	6/1/2023	
Silver Springs Care Center	iCare Health Network		52,914	46,328	52,914	159	$ -	$ 779,398.00		$ 59,623.95		$ 839,021.95	$ 36,934.60	$ 0.70	$ 32,337.49	6/1/2023	
Touchpoints at Bloomfield	iCare Health Network		41,531	36,456	49,275	150	$ -	$ 367,774.00		$ 28,134.71		$ 395,908.71	$ 17,428.30	$ 0.35	$ 12,894.29	6/1/2023	
Touchpoints at Chestnut	iCare Health Network		17,506	13,143	19,710	60	$ -	$ 296,268.00		$ 22,664.50		$ 318,932.50	$ 14,039.73	$ 0.71	$ 9,361.96	6/1/2023	
Touchpoints at Manchester	iCare Health Network		41,307	37,560	43,034	131	$ -	$ 528,893.00		$ 40,460.31		$ 569,353.31	$ 25,063.51	$ 0.58	$ 21,875.39	6/1/2023	
Trinity Hill Care Center	iCare Health Network		42,896	42,178	47,304	144	$ -	$ 314,569.00		$ 24,064.53		$ 338,633.53	$ 14,906.99	$ 0.32	$ 13,291.63	6/1/2023	
Westside Care Center	iCare Health Network		43,529	40,725	53,217	162	$ -	$ 573,101.00		$ 43,842.23		$ 616,943.23	$ 27,158.47	$ 0.51	$ 20,783.37	6/1/2023	
Bethel Health Care	National Health Care, Inc.		47,403	27,052	52,889	161	$ -	$ 34,982.00		$ 2,676.12		$ 37,658.12	$ 1,657.75	$ 0.03	$ 847.92	4/10/2023	
Bloomfield Health Care Center, LLC	National Health Care, Inc.		35,245	29,680	39,420	120	$ -	$ 47,151.00		$ 3,607.05		$ 50,758.05	$ 2,234.42	$ 0.06	$ 1,682.33	4/10/2023	
Maple View Center for Health and Rehabilitation	National Health Care, Inc.		36,985	24,899	39,420	120	$ -	$ 22,357.00		$ 1,710.31		$ 24,067.31	$ 1,059.47	$ 0.03	$ 669.20	4/10/2023	
Riverside Health and Rehabilitation Center	National Health Care, Inc.		105,485	90,753	113,333	345	$ -	$ 410,669.00		$ 31,416.18		$ 442,085.18	$ 19,461.04	$ 0.17	$ 15,583.70	3/27/2023	
The Pines at Bristol	National Health Care, Inc.		44,659	31,747	44,659	132	$ -	$ 51,553.00		$ 3,943.80		$ 55,496.80	$ 2,443.03	$ 0.05	$ 1,736.69	3/27/2023	
Aaron Manor Nursing and Rehab. Ctr	Ryder Health Management		19,498	10,782	19,710	60	$ -	$ 138,902.00		$ 10,626.00		$ 149,528.00	$ 6,582.37	$ 0.33	$ 3,600.77	4/1/2023	
Cheshire House Nursing & Rehab Center	Ryder Health Management		24,469	13,129	24,638	75	$ 68,796.00	$ -		$ -		$ 68,796.00	$ 3,028.47	$ 0.12	$ 1,613.80	4/1/2023	
Greentree Manor Nursing & Rehab. Ctr	Ryder Health Management		27,117	18,965	29,565	90	$ 206,388.00	$ -		$ -		$ 206,388.00	$ 9,085.41	$ 0.31	$ 5,828.00	4/1/2023	
Mystic Manor, Inc.	Ryder Health Management		29,497	18,895	32,850	100	$ 638,820.00	$ -		$ -		$ 638,820.00	$ 28,121.51	$ 0.86	$ 16,175.22	4/1/2023	
Civita Care Center at Danbury	Traditions Senior Management		27,310	22,668	39,420	120	$ 364,241.00	$ 156,103.00		$ 11,941.88		$ 532,285.88	$ 23,431.77	$ 0.59	$ 13,474.16	5/1/2023	
Civita Care Center at Long Ridge	Traditions Senior Management		24,697	18,504	39,420	120	$ 68,295.00	$ 29,269.00		$ 2,239.08		$ 99,803.08	$ 4,393.43	$ 0.11	$ 2,062.31	5/1/2023	
Civita Care Center at Milford	Traditions Senior Management		35,178	26,590	39,420	120	$ 244,462.00	$ 104,770.00		$ 8,014.91		$ 357,246.91	$ 15,726.37	$ 0.40	$ 10,607.92	5/1/2023	
Civita Care Center at Newington	Traditions Senior Management		44,969	33,628	59,130	180	$ 192,954.00	$ 82,694.00		$ 6,326.09		$ 281,974.09	$ 12,412.79	$ 0.21	$ 7,059.31	5/1/2023	
Civita Care Center at West River	Traditions Senior Management		37,227	26,263	39,420	120	$ 600,936.00	$ 257,544.00		$ 19,702.12		$ 878,182.12	$ 38,658.47	$ 0.98	$ 25,755.64	5/1/2023	
Advanced Center for Nursing			71,337	62,196	74,241	226	$ -	$ 223,860.00	$ 81,708.90	$ -	^	$ 305,568.90	$ 13,451.45	$ 0.18	$ 11,269.06	4/1/2023	
ARK Healthcare & Rehabilitation at Branford Hills			13,928	10,587	15,903	190	$ -	$ 298,480.00	$ 104,468.00	$ -	^	$ 402,948.00	$ 17,738.18	$ 1.12	$ 11,808.72	6/1/2023	
Colonial Health & Rehab Center of Plainfield, LLC			30,201	22,018	30,201	90	$ -	$ 441,223.51	$ 172,303.47	$ -	^	$ 613,526.98	$ 27,008.08	$ 0.89	$ 19,690.21	3/1/2023	
Cook Willow Health & Rehab Center			19,618	14,868	19,710	60	$ -	$ 87,360.00	$ 30,576.00	$ -	^	$ 117,936.00	$ 5,191.66	$ 0.26	$ 3,916.27	6/1/2023	
CT Baptist Home			20,191	15,952	20,212	60	$ -	$ 168,292.00		$ 12,874.34		$ 181,166.34	$ 7,975.13	$ 0.39	$ 6,294.24	1/1/2023	
Gladeview Health Care Center			35,373	22,894	43,362	132	$ -	$ 109,500.00		$ 8,376.75		$ 117,876.75	$ 5,189.05	$ 0.12	$ 2,739.68	3/1/2023	
Governor's House Simsbury OPCO, LLC			38,245	29,670	38,245	70	$ -	$ 174,720.00	$ 61,152.00	$ -	^	$ 235,872.00	$ 10,383.33	$ 0.27	$ 8,055.26	6/1/2023	
Harbor Village North Rehab and Nursing Center			42,190	36,992	42,190	128	$ 244,802.00	$ -		$ -		$ 244,802.00	$ 10,776.43	$ 0.26	$ 9,448.73	4/21/2023	
Leeway			10,516	9,275	10,516	30	$ -	$ 156,240.00		$ 11,952.36		$ 168,192.36	$ 7,404.00	$ 0.70	$ 6,530.25	4/1/2023	

Mattatuck Health Care Facility, Inc	13,561	12,693	14,126	43	$ -	$ 369,550.00	$ 103,474.00	$ -	^	$ 473,024.00	$ 20,823.00	$ 1.47	$ 18,710.63	6/1/2023
New Haven Center for Nursing and Rehab	41,810	37,208	45,090	150	$ -	$ 43,680.00	$ 15,943.20	$ -	^	$ 59,623.20	$ 2,624.67	$ 0.06	$ 2,165.87	4/1/2023
Orange Health Care Center	18,200	12,983	19,710	60	$ -	$ 14,560.00		$ 1,113.84		$ 15,673.84	$ 689.98	$ 0.04	$ 454.49	3/1/2023
Pilgrim Manor	19,141	9,283	19,710	60	$ -	$ 99,840.00		$ 7,637.76		$ 107,477.76	$ 4,731.28	$ 0.24	$ 2,228.33	3/1/2023
Southport Center for Nursing and Rehab	35,483	31,067	36,072	120	$ -	$ 165,984.00	$ 60,584.16	$ -	^	$ 226,568.16	$ 9,973.76	$ 0.28	$ 8,589.90	4/1/2023
St. Camillus Stamford OPCO, LLC	38,263	29,621	40,734	124	$ -	$ 218,400.00	$ 76,440.00	$ -	^	$ 294,840.00	$ 12,979.16	$ 0.32	$ 9,438.20	6/1/2023
The Villa at Stamford	42,502	27,678	42,502	128	$ -	$ 137,280.00	$ 48,048.00	$ -	^	$ 185,328.00	$ 8,158.33	$ 0.19	$ 5,312.84	4/1/2023
Torrington Center for Nursing and Rehab	23,902	17,265	23,902	75	$ -	$ 93,912.00	$ 34,277.88	$ -	^	$ 128,189.88	$ 5,643.05	$ 0.24	$ 4,076.11	4/1/2023
Twin Maples Healthcare	12,899	11,667	14,454	44	$ -	$ 421,937.00		$ 32,278.18		$ 454,215.18	$ 19,995.01	$ 1.38	$ 16,139.60	3/1/2023
Villa Maria Nursing & Rehabilitation	18,595	10,460	20,367	62	$ 210,864.00	$ -		$ -		$ 210,864.00	$ 9,282.45	$ 0.46	$ 4,767.24	4/21/2023
Waterbury Center for Nursing and Rehab	37,656	32,884	37,656	120	$ -	$ 55,692.00	$ 20,327.58	$ -	^	$ 76,019.58	$ 3,346.46	$ 0.09	$ 2,922.38	4/1/2023
West Haven Center for Nursing and Rehab	29,328	24,637	29,459	98	$ -	$ 65,520.00	$ 23,914.80	$ -	^	$ 89,434.80	$ 3,937.01	$ 0.13	$ 3,292.58	4/1/2023
Westview Health Care Center	35,312	13,915	35,312	103	$ -	$ 546,480.00		$ 41,805.72		$ 588,285.72	$ 25,896.94	$ 0.73	$ 10,204.91	4/3/2023
Windsor Health and Rehabilitation Center	32,471	26,902	35,478	108	$ -	$ 136,000.00		$ 10,404.00		$ 146,404.00	$ 6,444.85	$ 0.18	$ 4,886.96	6/1/2023
WV-Parkway Pavilion	42,530	28,369	42,705	130	$ 331,818.00	$ -		$ -		$ 331,818.00	$ 14,606.97	$ 0.34	$ 9,703.43	4/21/2023
Totals					$ 3,172,376	$ 17,003,571	$ 1,585,970	$ 954,505		$ 22,716,421	$ 1,000,000		$ 697,194	

**Based on Cost Year 2021 data. Did not file for Cost Year 2022

***Short period. 2022 costs and days have been annualized.

^Benefits were included in requested amount for application. Therefore, FICA does not need to be added.

EXHIBIT M

KFF Health News

Exclusive: CMS Study Sabotages Efforts to Bolster Nursing Home Staffing, Advocates Say

By Jordan Rau

AUGUST 29, 2023

(E+/GETTY IMAGES)

The Biden administration last year promised to establish minimum staffing levels for the nation's roughly 15,000 nursing homes. It was the centerpiece of an agenda to overhaul an industry the government said was rife with substandard care and failures to follow federal quality rules.

But a research study the Centers for Medicare & Medicaid Services commissioned to identify the appropriate level of staffing made no specific recommendations and analyzed only staffing levels lower than what the previous major federal evaluation had considered best, according to a copy of the study reviewed Monday by KFF Health News. Instead, the new study said there was no single staffing level that would guarantee quality care, although the report estimated that higher staffing levels would lead to fewer hospitalizations and emergency room visits, faster care, and fewer failures to provide care.

Patient advocates said the report was the latest sign that the administration would fall short of its pledge to establish robust staffing levels to protect the 1.2 million Americans in skilled nursing facilities. Already, the administration is six months behind its self-imposed deadline of February to

propose new rules. Those proposals, which have not been released, have been under evaluation since May by the Office of Management and Budget. The study, dated June 2023, has not been formally released either, but a copy was posted on the CMS website. It was taken down shortly after KFF Health News published this article.

“It’s honestly heartbreaking,” said Richard Mollot, executive director of the Long Term Care Community Coalition, a nonprofit that advocates for nursing home patients in New York state. “I just don’t see how this doesn’t ultimately put more residents at risk of neglect and abuse. Putting the government’s imprimatur on a standard that is patently unsafe is going to make it much more difficult for surveyors to hold facilities accountable for the harm caused by understaffing nursing homes.”

For months, the nursing home industry has been lobbying strenuously against a uniform ratio of patients to nurses and aides. “What is clear as you look across the country is every nursing home is unique and a one-size-fits-all approach does not work,” said Holly Harmon, senior vice president of quality, regulatory, and clinical services at the American Health Care Association, an industry trade group.

Nursing home groups have emphasized the widespread difficulty in finding workers willing to fill existing certified nursing assistant jobs, which are often grueling and pay less than what workers can make at retail stores. Homes say their licensed nurses are often drawn away by other jobs, such as better-paying hospital positions. “The workforce challenges are real,” said Katie Smith Sloan, president and CEO of LeadingAge, an association that represents nonprofit nursing homes.

The industry has also argued that if the government wants it to hire more workers it needs to increase the payments it makes through state Medicaid programs, which are the largest payor for nursing home care. Advocates and some researchers have argued that nursing homes, particularly for-profit ones, can afford to pay employees more and hire additional staff if they forsake some of the profits they give investors.

“Certainly, facilities haven’t put all the dollars back into direct care over the years,” said David Grabowski, a professor of health care policy at Harvard Medical School. “But for certain facilities, it’s going to be a big lift to pay for” higher staffing levels, he said in an interview last week.

In a written statement to KFF Health News, Jonathan Blum, CMS' principal deputy administrator and chief operating officer, said the study had been posted in error. "CMS is committed to holding nursing homes accountable for protecting the health and safety of all residents, and adequate staffing is critical to this effort," he said. "CMS's proposal is being developed using a rigorous process that draws on a wide range of source information, including extensive input from residents and their families, workers, administrators, experts, and other stakeholders. Our focus is on advancing implementable solutions that promote safe, quality care for residents." Blum's statement called the study a "draft," although nothing in the 478-page study indicated it was preliminary.

The study has been widely anticipated, both because of the central role the administration said it would play in its policy and because the last major CMS study, conducted in 2001, had concluded that nursing home care improves as staffing increases up to the level of about one worker for every six residents. The formal metric for that staffing level was 4.1 staff hours per resident per day, which is calculated by dividing the number of total hours worked by nurses and aides on duty daily by the number of residents present each day.

CMS never adopted that staffing ratio and instead gave each nursing home discretion to determine a reasonable staffing level. Regulators rarely cite nursing homes for insufficient staffing, even though independent researchers have concluded low staffing is the root of many nursing home injuries. Too few nurse aides, for instance, often means immobile residents are not repositioned in bed, causing bedsores that can lead to infection. Low staffing also is often responsible for indignities residents face, such as being left in soiled bedsheets for hours.

The new research was conducted by Abt Associates, a regular contractor for CMS that also performed the 2001 study. But the report, in an implicit disagreement with its predecessor, concluded there was "no obvious plateau at which quality and safety are maximized or 'cliff' below which quality and safety steeply decline." Abt referred questions about the study to CMS.

The study evaluated four minimum staffing levels, all of which were below the 4.1 daily staff hours that the prior study had identified as ideal. The highest was 3.88 daily staff hours. At that level, the study estimated 0.6% of residents would get delayed care and 0.002% would not get needed care. It also said that staffing level would result in 12,100 fewer hospitalizations of Medicare residents and 14,800 fewer emergency room visits. The report said three-quarters of nursing homes would need to add staff to meet that level and that it would cost $5.3 billion extra each year.

The lowest staffing level the report analyzed was 3.3 daily staffing hours. At that level, the report said, 3.3% of residents would get delayed care and 0.04% would not get needed care. That level would reduce hospitalizations of Medicare residents by 5,800 and lead to 4,500 fewer emergency room visits. More than half of nursing homes would have to increase staff levels to meet that ratio, the report said, and it would cost $1.5 billion more each year.

Charlene Harrington, a professor emeritus of nursing at the University of California-San Francisco, said CMS “sabotaged” the push for sufficiently high staffing through the instructions it gave its contractor. “Every threshold they looked at was below 4.1,” she said. “How can that possibly be a decent study? It’s just unacceptable.”

Nursing Home Staffing

The federal government tallies the number of nurse and aide staffing hours each day for residents at each of the nation's roughly 15,000 nursing homes. It ranks each facility on a five-star scale, with five as the highest, after taking into account how frail the home's patients and residents are. This chart also displays the percentage of the home's staff who leave within a year. The national turnover average is 54%; lower turnover rates are considered superior.

Staff turnover:

Lowest Highest

Search by facility, city, or state ...

Facility	City	State	Ownership	Daily staffing hours per resident	Staffing star rating	Staff turnover
CORDOVA COMMUNITY MED LTC	CORDOVA	Alaska	Government	7.96	★★★★★	
DENALI CENTER	FAIRBANKS	Alaska	Nonprofit	5.77	★★★★★	47%
HERITAGE PLACE	SOLDOTNA	Alaska	Nonprofit	5.90	★★★★★	38%
KETCHIKAN MED CTR NEW HORIZONS TRANSITIONAL CARE	KETCHIKAN	Alaska	For-profit	8.34	★★★★	60%
MAPLE SPRINGS OF PALMER	PALMER	Alaska	For-profit	5.22	★★★★★	51%
MAPLE SPRINGS OF WASILLA	WASILLA	Alaska	For-profit	5.31	★★★★★	
PETERSBURG MEDICAL CENTER LTC	PETERSBURG	Alaska	Government			51%
PRESTIGE CARE & REHAB CENTER OF ANCHORAGE	ANCHORAGE	Alaska	For-profit	4.85	★★★★	52%
PROVIDENCE EXTENDED CARE	ANCHORAGE	Alaska	Nonprofit	5.24	★★★★★	41%
PROVIDENCE KODIAK ISLAND MED LTC	KODIAK	Alaska	Nonprofit			35%
PROVIDENCE SEWARD MOUNTAIN HAVEN	SEWARD	Alaska	Government	6.86	★★★★	64%
PROVIDENCE TRANSITIONAL CARE CENTER	ANCHORAGE	Alaska	For-profit	6.80	★★★★★	43%
PROVIDENCE VALDEZ MEDICAL CENTER	VALDEZ	Alaska	Government	9.25	★★★★★	56%
QUYANNA CARE CENTER	NOME	Alaska	Nonprofit			89%
SEARHC SITKA LONG TERM CARE	SITKA	Alaska	Nonprofit	8.95	★★★★★	40%
SOUTH PENINSULA HOSPITAL LTC	HOMER	Alaska	Nonprofit	8.50	★★★★★	37%

UTUQQANAAT INAAT	KOTZEBUE	Alaska	For-profit	8.74	★★★★	80%
WILDFLOWER COURT	JUNEAU	Alaska	Nonprofit	5.56	★★★★★	55%
WRANGELL MEDICAL CENTER LTC	WRANGELL	Alaska	Nonprofit	12.87	★★★★	62%
YUKON KUSKOKWIM ELDER'S HOME	BETHEL	Alaska	Nonprofit	11.62	★★★★★	50%

‹ 1 / 751 ›

Note: Blank cells mean that facility did not submit staffing data or submitted data that did not meet the criteria required to calculate a staffing measure.
Source: Centers for Medicare & Medicaid Services • Click here to download the data (CSV)
Credit: Lydia Zuraw and Jordan Rau/KFF Health News

A Flourish data visualization

*[**UPDATE:** This article was last revised at 3:30 p.m. ET to reflect that the Centers for Medicare & Medicaid Services removed a copy of the study from its website after this article was published, and to include reaction from CMS leadership and Abt Associates.]*

Jordan Rau: jrau@kff.org, @JordanRau

RELATED TOPICS

AGING HEALTH INDUSTRY MULTIMEDIA BIDEN ADMINISTRATION CMS NURSING HOMES STUDY

EXHIBIT N

From: Salton, Henry <Henry.A.Salton@ct.gov>
Sent: Friday, September 29, 2023 1:05 PM
To: Ross, Kathleen; Jennifer L. Morgan; Lorey Rives Leddy
Cc: Yandow, Joanne; Peluso, Tyra
Subject: [EXTERNAL] RE: Request for Reconsideration of Declaratory Ruling

Attorney Delmonico and Attorney Leddy

In regards to the CAHCF's Request for Reconsideration of Declaratory Rulings (corrected), filed with the Commissioner on September 8, 2023, please be advised that upon further review, the Department has concluded that the motion was not authorized pursuant to Conn. Gen. Stat. § 4-181a(a)(1) which permits "a party in a contested case" to file a motion for reconsideration of the final decision. Conn. Gen. Stat. § 4-166 defines contested case as excluding proceedings on a petition for a declaratory ruling under Conn. Gen. Stat. § 4-176. Therefore, the motion for reconsideration was not authorized by Conn. Gen. Stat. § 4-181a(a)(1).

While your motion specifically cited Conn. Gen. Stat. § 4-181a(a) as authority for your motion, you should be aware that the Commissioner will not be reconsidering the ruling in accord with Conn. Gen. Stat. § 4-181a(2).

To the extent that CAHCF intends to seek judicial review of the ruling, Conn. Gen. Stat. § 4-183(c) provides the deadlines for such an appeal.

If you have any questions, please feel free to contact me.

Henry Salton, Esq.
Counsel to the Commissioner
Connecticut Department of Public Health

Cell: 860-559-8007

From: Ross, Kathleen <Kathleen.Ross@ct.gov>
Sent: Tuesday, September 12, 2023 9:24 AM
To: jdelmonico@murthalaw.com; Lorey Rives Leddy <lleddy@murthalaw.com>
Cc: Yandow, Joanne <Joanne.Yandow@ct.gov>; Peluso, Tyra <Tyra.Peluso@ct.gov>; Salton, Henry <Henry.A.Salton@ct.gov>
Subject: Request for Reconsideration of Declaratory Ruling

Good morning,

The Department is in receipt of CAHCF's Request for Reconsideration of Declaratory Rulings (corrected), filed with the Department on September 8, 2023.

In accordance with Conn. Gen. Stat. §4-181a(a)(1), the Department will decide whether to reconsider the Declaratory Rulings by October 3, 2023.

Thank you.

Kathleen K. Ross
Legal Director
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
(860) 509-7152 office
(860) 993-2834 cell

Let us know how we are doing: Survey

EXHIBIT O

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

BLAST FAX 2022-14

TO: All Nursing Home Administrators

FROM: Manisha Juthani, MD, Commissioner Department of Public Health

Deidre S. Gifford, MD, MPH, Commissioner of Social Services

CC: Heather Aaron, MPH, LNHA, Deputy Commissioner
Adelita, Orefice, MPM, JD, CHC, Chief of Staff
Barbara Cass, RN, Branch Chief, Healthcare Quality and Safety Branch
Donna Ortelle, Section Chief, Facility Licensing and Investigations Section

DATE: February 9, 2022

SUBJECT: Nursing Home Minimum Staffing Level Requirements

The Departments of Public Health and Social Services wish to express shared ongoing support and collaboration with the nursing home industry in addressing the COVID-19 public health emergency. Since 2020, the state has partnered with the industry to prioritize quality support of Connecticut nursing facility residents in the form of Medicaid rate increases, financial supports, distribution of millions of pieces of PPE, continued attention to infection control, testing, and COVID-19 vaccinations. The Departments recognize current challenges related to staffing shortages and therefore, wish to make you aware of legislation that passed during the 2021 session in section 10 of Public Act 21-185 regarding minimum staffing level requirements for nursing homes. The Department of Social Services has made funding available to nursing homes to meet the staffing requirements.

Pursuant to this Public Act, the Department of Public Health is required to adopt regulations on or before January 1, 2022, that establish staffing level requirements where nursing homes must:

Connecticut Department of Public Health

Phone: (860) 509-7101 • Fax: (860) 509-7111
Telecommunications Relay Service 7-1-1
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

1. Have a minimum of three hours of direct care per resident per day;
2. Have one full-time social worker per sixty residents; and
3. Lower the requirements for recreational staff as deemed appropriate by the Commissioner of Public Health.

The Department of Public Health is in the process of modifying subsections (m), (r) and (s) of Section 19-13-D8t of the Regulations of Connecticut State Agencies to comply with this public act and requirement number 3 outlined above. These subsections govern minimum staffing levels for nursing, nurse aides, social workers, and recreation in a nursing home. The required regulatory revisions will not be in place by January 1, 2022. However, since these current regulations are minimum staffing levels, nursing homes are encouraged to begin to comply with staffing requirements 1 and 2 outlined above and in public Act 21-185 within their facilities so they can be prepared for the Department's adoption of the new regulations.

Nursing homes may apply to the Department of Social Services for funding supports. The Department has been allocated $2,500,000 in state funding, for Medicaid, for each of the fiscal years ending June 30, 2022 and June 30, 2023, to support nursing homes in meeting the minimum staffing level requirement for social workers. DSS has also received an allocation of $500,000 in state funding, for Medicaid, to support nursing homes in meeting the staffing requirement of three-hours of direct care per resident per day. Nursing homes not currently providing staffing to meet the staffing requirements, may complete an application to be considered for a Medicaid rate increases. Applications and information are now available at the DSS webpage. Please visit:

https://portal.ct.gov/dss/Health-And-Home-Care/Medicaid-Nursing-Home-Reimbursement/Medicaid-Nursing-Home-Reimbursement

If you have any further questions regarding the staffing levels outlined in the Public Act, please email the Department of Public Health at Dph.flisadmin@ct.gov. This mailbox is checked daily by supervisors in the Facility Licensing and Investigations Section.

Section 10 of Public Act No. 21-185

AN ACT CONCERNING NURSING HOMES AND DEMENTIA SPECIAL CARE UNITS.

Sec. 10. (NEW) (*Effective October 1, 2021*) (a) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for nursing homes of three hours of direct care per resident per day, and (2) modify staffing level requirements for social work and recreational staff of nursing homes such that the requirements (A) for social work are one full-time social worker per sixty residents, and (B) for recreational staff are lower than the current requirements, as deemed appropriate by the Commissioner of Public Health.

(b) The commissioner shall adopt regulations in accordance with the provisions of chapter 54 of the general statutes that set forth nursing home staffing level requirements to implement the provisions of this section.

EXHIBIT P

Agenda

1. Introductions
2. Nursing Home Data
3. New Nursing Home Data Page
4. Resident Up to Date Vaccination Data
5. Mobile COVID Clinics
6. General Survey Stats
7. Implementing and Enforcing the New Staffing 3.0 Staffing Ratio

1

COVID-19 Nursing Home Data

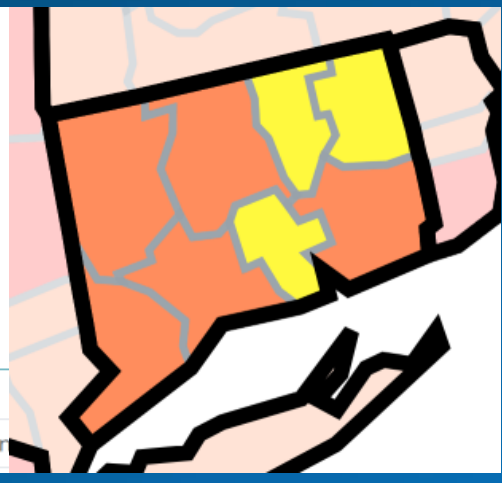
2

Community Transmission

7-day Metrics	
Cases	2,138
% Positivity	N/A %
Deaths	26
% of Population ≥ 5 Years of Age with a Completed a Primary Series	87%
New Hospital Admissions (7-Day Moving Avg)	55.86

Data Type: Community Transmission

Map Metric: Community Tran



*As of 2/22/23

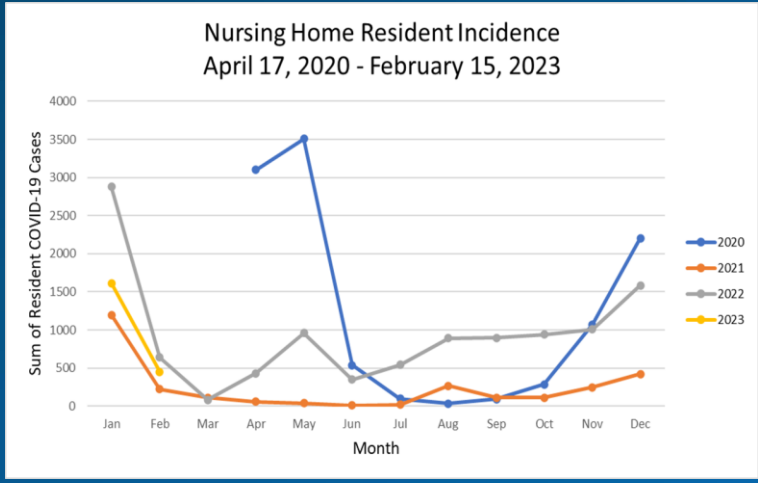
Source: CDC COVID Tracker

3

3

Nursing Home Resident Incidence, Statewide April 16, 2020 – February 15, 2023

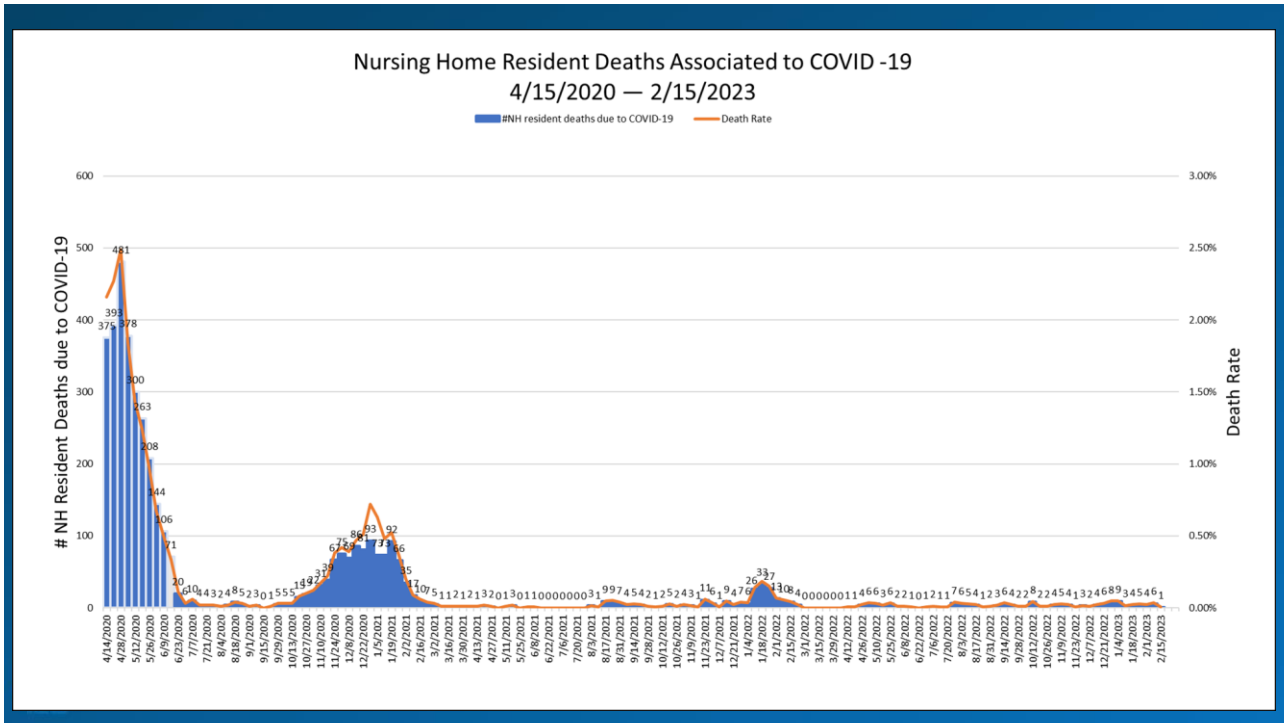
Resident Census: 19,337



Date Reported	New Resident Cases
23-Nov	182
30-Nov	207
7-Dec	272
14-Dec	330
21-Dec	432
28-Dec	548
4-Jan	536
11-Jan	388
18-Jan	379
25-Jan	309
1-Feb	193
8-Feb	139
15-Feb	119

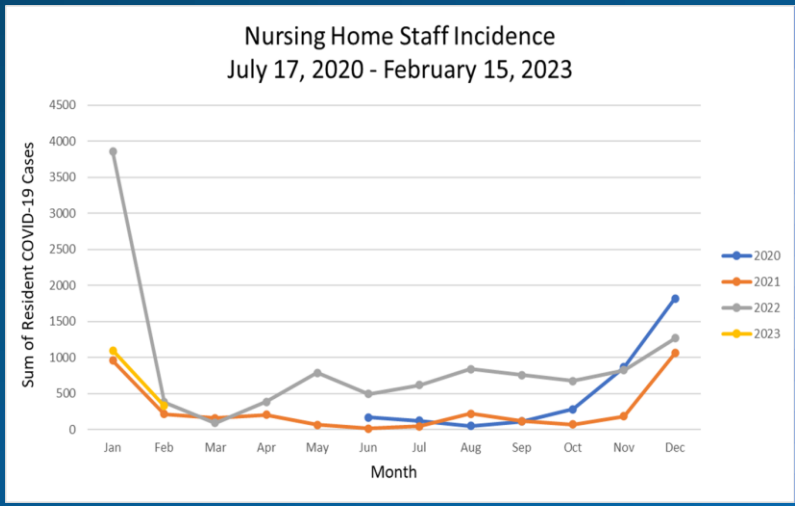
4

4



5

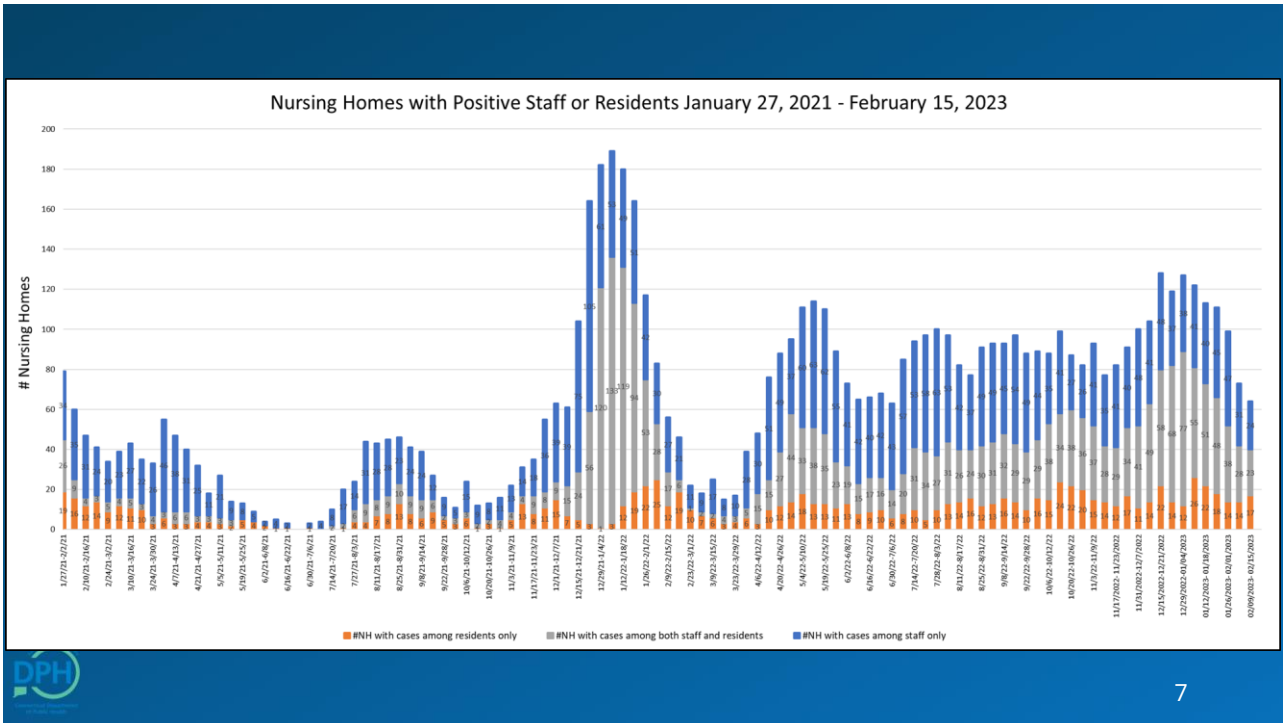
Nursing Home Staff Incidence, Statewide June 17, 2020 – February 15, 2023



Date Reported	New Staff Cases
23-Nov	150
30-Nov	218
7-Dec	232
14-Dec	338
21-Dec	311
28-Dec	386
4-Jan	406
11-Jan	280
18-Jan	226
25-Jan	184
1-Feb	144
8-Feb	106
15-Feb	79

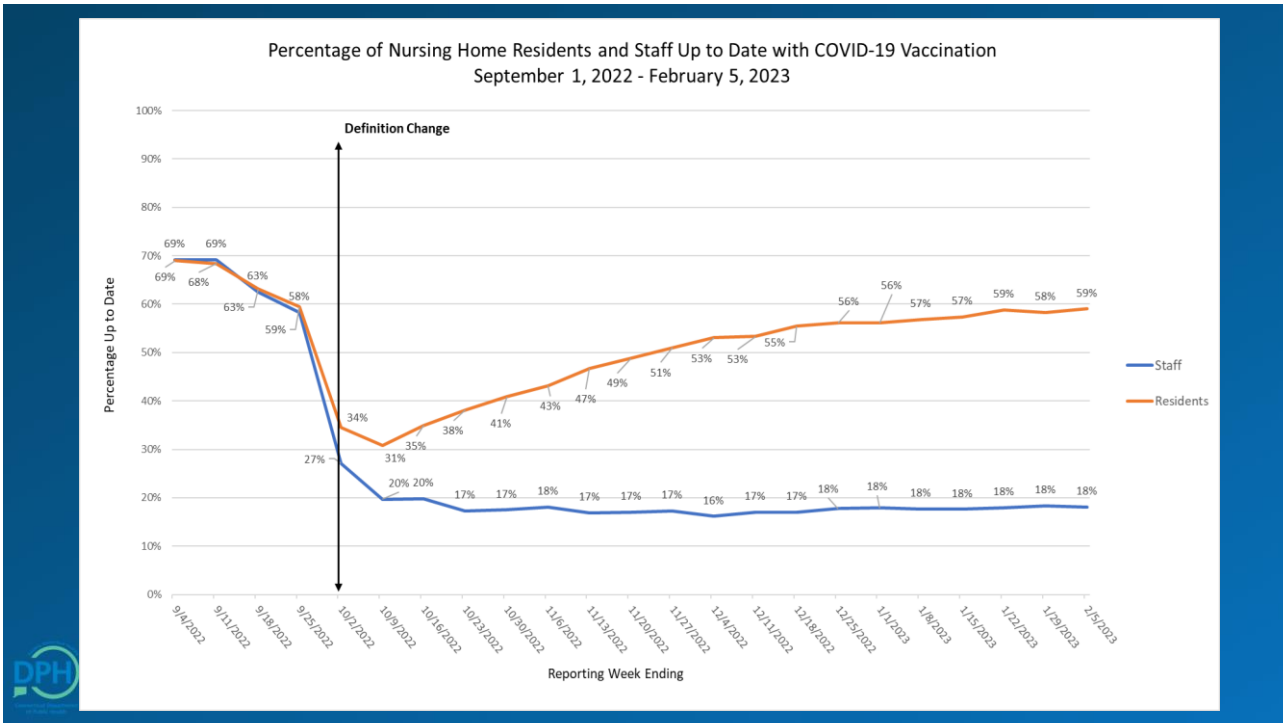
6

6


Nursing Homes with Positive Staff or Residents January 27, 2021 - February 15, 2023
Nursing Homes
#NH with cases among residents only
#NH with cases among both staff and residents
#NH with cases among staff only

7

7


Percentage of Nursing Home Residents and Staff Up to Date with COVID-19 Vaccination
September 1, 2022 - February 5, 2023
Definition Change
Percentage Up to Date
Reporting Week Ending
Staff
Residents

8

Blast Fax 2023-4: Increasing COVID-19 Vaccination Rates Among Nursing Home Residents

- Risk of severe illness and death from COVID-19 increases exponentially with age. Recent data shows that adults aged 65-74 are 5x more likely to be hospitalized and 60x more likely to die because of COVID-19, and those aged 85+ are 15x more likely to be hospitalized and 340x more likely to die from COVID-19.
- COVID-19 vaccines are working well to prevent severe illness, hospitalization, and death. However, vaccine effectiveness wanes over time and the emergence of new variants further emphasizes the importance of vaccination and boosters.
- Starting January 20, 2023 CT DPH will display staff and resident vaccination data reported by nursing homes in the NHSN system on the COVID-19 In Nursing Homes Page.

Source: Blast Fax 2023-4

9

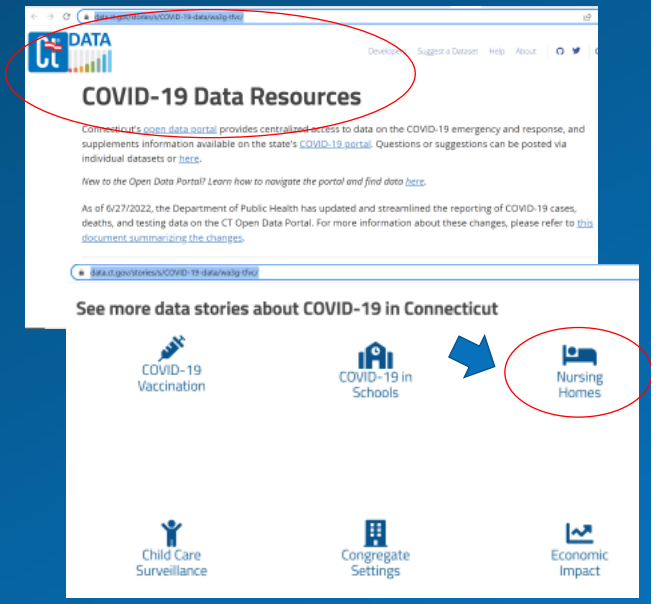
9

COVID-19 in Nursing Home Page

We have revamped the nursing home data page!

To access the page:

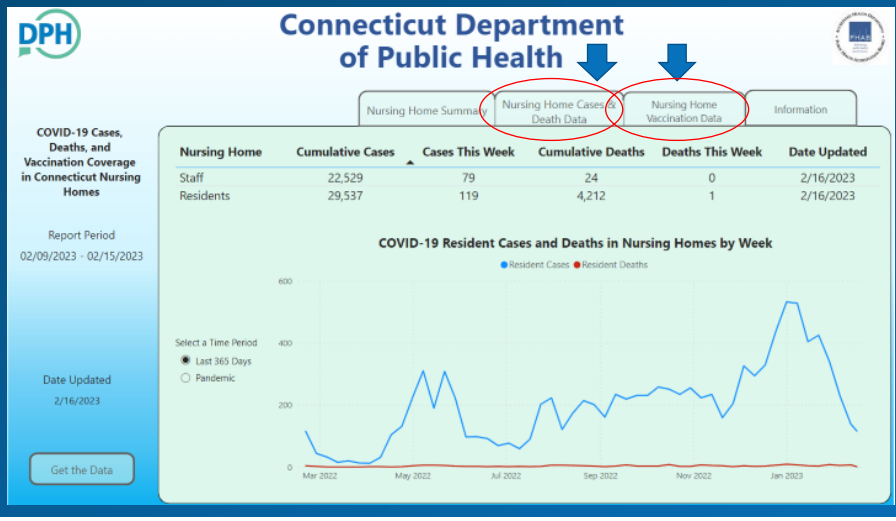
1. Go to the COVID-19 Data Resources Home Page
2. Scroll to the middle of the page and click the Nursing Homes icon



10

COVID-19 in Nursing Homes Page

- This new version is far more interactive, and each tab allows you to view different data. Above the chart, you will see tabs for Nursing Home Cases and Nursing Home Vaccination Data



11

11

Nursing Home Vaccination Data

Nursing Home	Town	% Residents Up to Date
Orange Health Care Center	Orange	100%
The Bradley Home	Meriden	97%
Twin Maples Health Care Facility	Durham	97%
Cobalt Health Care & Rehabilitation Center	East Hampton	96%
St. Joseph Residence	Enfield	96%
Touchpoints at Chestnut	East Windsor	96%
Harbor Village	New London	95%
The Suffield House	Suffield	95%
CT Baptist Homes Inc.	Meriden	95%
Avon Health Center	Avon	94%
Crestfield rehabilitation Center and Fenwood Manor	Manchester	94%
Apple Rehab West Haven	West Haven	94%
Kimberly Hall North	Windsor	93%
Bishop-Wicke Health and Rehabilitation	Shelton	93%
Apple Rehab Saybrook	Old Saybrook	92%
LiveWell	Southington	92%
Saint Joseph Living Center	Windham	92%

Nursing Home	Town	% Residents Up to Date
The John L. Levitow Health Care Center	Rocky Hill	91%
West Hartford Health & Rehabilitation Center	West Hartford	91%
Caleb Hitchcock Health Center	Bloomfield	90%
Seabury Health Center	Bloomfield	90%
Essex Meadows Health Center	Essex	90%
Gladeview Rehabilitation and Health Care	Old Saybrook	90%
Monsignor Bojnowski Manor	New Britain	89%
Chesterfield's Health Care Center	Chester	89%
Mattatuck Health Care Facility	Waterbury	89%
Portland Care & Rehabilitation Centre	Portland	88%
Evergreen Woods Health Center	North Branford	87%
Noble Horizons	Salisbury	87%
Regency House of Wallingford	Wallingford	86%
Vernon Manor Health Care Center	Vernon	86%
Mansfield Center for Nursing & Rehabilitation	Mansfield	86%
60 West	Rocky Hill	85%
Jewish Senior Services	Bridgeport	85%
The Summit at Plantsville	Southington	85%

12

12

Mobile COVID Clinics

- DPH's COVID-19 mobile vaccine clinic program is available to conduct vaccine clinics at long-term care facilities throughout the state
- Open to everyone - residents, staff and family members
- Nursing homes interested in scheduling a mobile vaccination clinic can visit: **ct.gov/dph/mobilevaccines** and **complete the required online intake form.**

13

13

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

Survey Findings

14

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

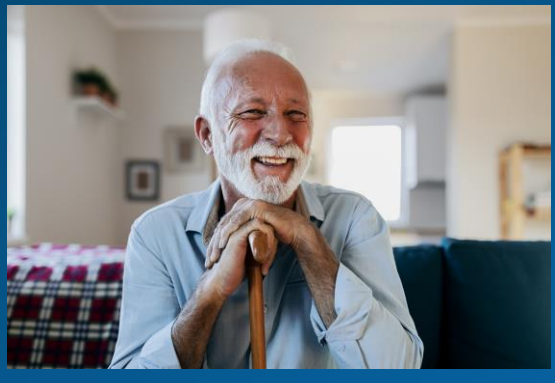
Staffing 3.0

15

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

Public Act 22-58

An Act Concerning the Department of Public Health's Recommendations Regarding Various Revisions to the Public Health Statutes



https://www.cga.ct.gov/2022/act/pa/pdf/2022PA-00058-R00HB-05500-PA.pdf

Sec. 36. Section 19a-563h of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (Effective from passage): (a) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for nursing homes of three hours of direct care per resident per day, and (2) modify staffing level requirements for social work and recreational staff of nursing homes such that the requirements (A) for social work, [are] a number of hours that is based on one full-time social worker per sixty residents and that shall vary proportionally based on the number of residents in the nursing home, and (B) for recreational staff are lower than the current requirements, as deemed appropriate by the Commissioner of Public Health. (b) The commissioner shall adopt regulations in accordance with the provisions of chapter 54 that set forth nursing home staffing level requirements to implement the provisions of this section. ***The Commissioner of Public Health may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulations, provided notice of intent to adopt regulations is published on the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.***

16

16

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

The proposed regulation amends Section 19-13-D8t(m) of the Regulations of Connecticut General Statutes to add a definition of "direct care staff", to require minimum direct care staffing levels of three hours of direct care per resident per day, and to set standards for nursing personnel per resident in nursing homes and rest homes with nursing supervision. The proposed regulation further amends subsection (r) of Section 19-13-D8t to revise the minimum staffing requirements for therapeutic recreation directors in a nursing home or rest home with nursing supervision. Lastly the proposed regulation amends subsection (s) of Section 19-13-D8t to modify the requirements for social work service staffing to ensure sufficient staffing to meet the needs of residents proportional to the number of residents.

Notably: The requirements for Rest Home with Nursing Supervision (RHNS) have been deleted, rather one requirement for the building.

17

17

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

(1) Each facility shall employ sufficient nurses and nurse's aides to provide appropriate care of patients housed in the facility 24 hours per day, seven days per week.
The number, qualifications, and experience of such personnel shall be sufficient to assure that each patient:
receives treatment, therapies, medications and nourishments as prescribed in the patient care plan developed pursuant to subsection (o) (2) (I) of these regulations;
is kept clean, comfortable and well groomed;
is protected from accident, incident, infection, or other unusual occurrence.

The facility's administrator and director of nurses shall meet at least once every 30 days in order to determine the number, experience and qualifications of staff necessary to comply with this section. The facility shall maintain written and signed summaries of actions taken and reasons therefore.

There shall be at least one registered nurse on duty 24 hours per day, seven days per week.

18

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

Policy and Procedures

Collaboration with Stakeholders including LTCOP, Leading Age and CAHCF
Comments considered and a few were accepted
Office of Policy and Management approval
Posted in Eregulation system 11/21/22
Blast Fax to the industry on 12/2/22
NEXT STEPS
Notice of Intent: 2/15/23
Implementation Date: March 1, 2023
Public Comment Period: July 15-August 15, 2023

https://eregulations.ct.gov/eRegsPortal/Browse/RCSA

19

19

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What changed?

Minimum staffing levels of three hours of direct care per resident day, an increase of 0.46 hours per day

20

20

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

PA 22-58, Policy and Procedures

[(5)] (6) In no instance shall a chronic and convalescent nursing home, or rest home with nursing supervision have staff below the following standards:

(A) Licensed nursing personnel:

7 a.m. to 9 p.m.: [.47] .57 hours per [patient] resident

9 p.m. to 7 a.m.: [.17] .27 hours per [patient] resident

(B) [Total nursing and] Nurse's aide personnel:

1

Connecticut eRegulations System — Tracking Number PR2022-032 — Posted 11/21/2022

7 a.m. to 9 p.m.: [1.40] 1.60 hours per [patient] resident

9 p.m. to 7 a.m.: [.50] .56 hours per [patient] resident

[(6) In no instance shall a rest home with nursing supervision staff below the following standards:

(A) Licensed nursing personnel:

7 a.m. to 9 p.m.: .23 hours per patient

9 p.m. to 7 a.m.: .08 hours per patient

(B) Total nursing and nurse's aide personnel:

7 a.m. to 9 p.m.: .70 hours per patient

9 p.m. to 7 a.m.: .17 hours per patient]

[(7) In facilities of 61 beds or more, the] (7) The director of nurses or the assistant director of nurses shall not be included in satisfying the requirements of [subdivisions] subdivision (5) [and (6)] of this subsection.

21

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

FACILITY LICENSING AND INVESTIGATIONS SECTION

BLAST FAX 2022-33

TO: Chronic and Convalescent Nursing Homes, and Rest Homes with Nursing Supervision Administrators

FROM: Manisha Juthani, MD, Commissioner

CC: Deputy Commissioner Heather Aaron, MPH, LNHA
Adelita Orefice, MPM, JD, CHC, Chief of Staff
Barbara Cass, R.N. Acting Section Chief
Cheryl Davis, R.N. Public Health Services Manager
Kim Hricenak, R.N. Public Health Services Manager

DATE: December 2, 2022

SUBJECT: Policy and procedures to implement nursing staffing levels as required by Section 19a-536h of the Connecticut General Statutes.

Please see the attached Policies and Procedures posted to the Connecticut eRegulations System, November 21, 2022.

They can also be accessed at the link below:

https://eregulations.ct.gov/eRegsPortal/Search/getDocument?guid=1A00A9B84-0000-CF19-9BE0-C964E80B458D1

22

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What Else

Previous Requirements

19-13-d8t (s) **Social Work.**

(5) Social work service staff shall be employed in each facility sufficient to meet the needs of the **patients** but not less than the following ratio of hours per week to the number of **licensed beds** in the facility:

(A) One (1) to thirty (30) **beds,** ten (10) hours per week.

(B) Thirty-one (31) to sixty (60) beds, twenty (20) hours per week.

(C) Each additional thirty (30) beds or fraction thereof, ten (10) additional hours.

Public Act 22-58/P+P

(5) Social work service staff shall be employed in each facility sufficient to meet the needs of the residents but not less than one full-time social worker for a nursing home with sixty residents, such total number of hours shall vary proportionally based on the number of residents in the nursing home based on the following ratio of hours per week to the number of residents in the facility:

(A) One to thirty residents, sixteen hours per week.

(B) Thirty-one residents or greater, sixteen hours per week plus 1.6 hours for each additional three residents in excess of thirty residents.*

23

23

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Therapeutic Recreation

Previous Requirements

(3) Therapeutic recreation director(s) shall be employed in each facility sufficient to meet the following ratio of hours per week to the number of licensed beds in the facility:

1 to 15 beds, 10 hours during any three days;

16 to 30 beds, 20 hours during any five days;

Each additional 30 beds or fraction thereof, 20 additional hours.

PA 22-58/P+P

(3) Therapeutic recreation director or directors shall be employed in each facility sufficient to meet the following ratio of hours per week to the number of licensed beds in the facility:

(A) 1 to 15 beds, nine hours during any three days;

(B) (B) 16 to 30 beds, nineteen hours during any five days; and

(C) Each additional 30 beds or fraction thereof, nineteen additional hours.

24

24

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Facility Name: _____
Provider Number: _____
Surveyor Name_____
Surveyor Number: _____ Discipline: _____
Staffing Dates: From _____ To _____

SURVEYOR NOTES WORKSHEET- Staffing *Census:*

Date:

7 a.m.- 9p.m.			9p.m.- 7a.m.	
License	Need	Have 7-3P ____x8 3-9P ____x6	Need	Have 9-11P____x2 11-7A____x8
Nurse Aide	Need	Have 7-3P ____x8 3-9P ____x6	Need	Have 9-11P____x2 11-7A____x8

Date:

7 a.m.- 9p.m.			9p.m.- 7a.m.	
License	Need	Have 7-3P ____x8 3-9P ____x6	Need	Have 9-11P____x2 11-7A____x8
Nurse Aide	Need	Have 7-3P ____x8 3-9P ____x6	Need	Have 9-11P____x2 11-7A____x8

	7:00A.M. – 9:00 p.m.				9:00 p.m.-7:00 a.m.		
Residents	License	N/A	Totals	Residents	License	N/A	Total
10	5.7	16.0	21.7	10	2.7	5.6	8.3
20	10.4	32.0	42.0	20	5.4	11.2	16.6
30	17.1	48.0	65.1	30	8.1	16.8	24.9
40	22.8	64.0	86.8	40	10.8	22.4	33.2
50	28.5	80.0	108.5	50	13.5	28	41.5
60	34.2	96.0	130.2	60	16.2	33.6	49.8
70	39.9	112.0	151.9	70	18.9	39.2	58.1
80	45.6	128.0	173.6	80	21.6	44.8	66.4
90	51.3	144.0	195.3	90	24.3	50.4	74.7
100	57.0	160.0	274.0	100	27	56	83

25

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Enforcement

Sec. 19a-562h. Failure to comply with nursing home facility staffing level requirement. Disciplinary action and citation. Posting and inclusion in Department of Public Health listing. (a) If the Commissioner of Public Health finds that a nursing home facility has substantially failed to comply with a nursing home facility staffing level requirement established pursuant to the regulations of Connecticut state agencies, the commissioner may (1) take any disciplinary action against the nursing home facility permitted under section 19a-494, and (2) issue or cause to be issued a citation to the licensee of such nursing home facility pursuant to the provisions of section 19a-524.

(b) A citation of a nursing home facility staffing level requirement set forth in the regulations of Connecticut state agencies shall be prominently posted in the nursing home facility and included in the listing prepared by the Department of Public Health pursuant to the provisions of section 19a-540. ***(P.A. 19-89, S. 3.)***

26

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

(m) **Nursing staff:**
(1) Each facility shall employ sufficient nurses and nurse's aides to provide appropriate care of patients housed in the facility 24 hours per day, seven days per week.
(2) The number, qualifications, and experience of such personnel shall be sufficient to assure that each patient:
(A) receives treatment, therapies, medications and nourishments as prescribed in the patient care plan developed pursuant to subsection (o) (2) (I) of these regulations;
(B) is kept clean, comfortable and well groomed;
(C) is protected from accident, incident, infection, or other unusual occurrence.
(3) The facility's administrator and director of nurses shall meet at least once every 30 days in order to determine the number, experience and qualifications of staff necessary to comply with this section. The facility shall maintain written and signed summaries of actions taken and reasons therefore.

27